

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04668

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

Item 8, Film G158, 6/1/56 bh

1. PLACE OF DEATH a. COUNTY <b>ANNE ARUNDEL</b> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MD.</b> b. COUNTY <b>AA.</b>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>		c. LENGTH OF STAY IN 1b <b>1 month</b>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Edgewater</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Anne Arundel Hospital</b>			d. STREET ADDRESS <b>Box 36-B. Rt. 2</b>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
3. NAME OF DECEASED (Type or print) First <b>Emma</b> Middle <b>H.</b> Last <b>actm</b>			4. DATE OF DEATH Month <b>5</b> - Day <b>23</b> Year <b>1956</b>		
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>11-25-1889</b>	9. AGE (In years last birthday) <b>66</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>At home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>	
13. FATHER'S NAME <b>Edwin Howard</b>			14. MOTHER'S MAIDEN NAME <b>Martha E. McKenny</b>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b>		16. SOCIAL SECURITY NO. <b>Unknown</b>		17. INFORMANT Address <b>Ms. Joseph W. Smith Edgewater Md.</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>metastatic carcinoma liver</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <b>Carcinoma cecum + lower ileum</b> DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)					19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town)		20g. (County)		20h. (State)	
21. I certify that I attended the deceased from <b>April 3<sup>rd</sup></b> , 19 <b>56</b> , to <b>May 23</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>May 22</b> , 19 <b>56</b> , and that death occurred at <b>6:41</b> A.M. from the causes and on the date stated above.					
ACTUAL SIGNATURE <b>Emily H. Wilson</b>			DATE SIGNED <b>5-23-56</b>		
PHYSICIAN'S NAME (Type)			ADDRESS (Street, city or town, state) <b>Lothian, Md.</b>		
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5-26-56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Edgar Hill Cem.</b>	
22d. LOCATION (City, town, or county) <b>Shutland Maryland</b>		22e. (State) <b>Md.</b>		22f. (Country) <b>U.S.A.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>W. W. Chambers Co. 517 H St. S.E.</b>			24. REC'D BY REGISTRAR DATE <b>5/25/56</b>		
24b. REGISTRAR'S SIGNATURE <b>Wm. J. French</b>			24c. (City or town)		

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE		4. RACE		5. DATE OF BIRTH		6. PLACE OF BIRTH		7. COUNTY		8. STATE	
9. DATE OF DEATH		10. TIME OF DEATH		11. PLACE OF DEATH		12. CAUSE OF DEATH		13. MANNER OF DEATH		14. MEDICAL HISTORY		15. SOCIAL HISTORY		16. OCCUPATION	
17. SIGNATURE OF PHYSICIAN		18. SIGNATURE OF REGISTRAR		19. SIGNATURE OF WITNESS		20. SIGNATURE OF DECEASED		21. SIGNATURE OF NEXT OF KIN		22. SIGNATURE OF CLERK		23. SIGNATURE OF JUDGE		24. SIGNATURE OF SHERIFF	
25. SIGNATURE OF DECEASED		26. SIGNATURE OF NEXT OF KIN		27. SIGNATURE OF CLERK		28. SIGNATURE OF JUDGE		29. SIGNATURE OF SHERIFF		30. SIGNATURE OF DECEASED		31. SIGNATURE OF NEXT OF KIN		32. SIGNATURE OF CLERK	
33. SIGNATURE OF JUDGE		34. SIGNATURE OF SHERIFF		35. SIGNATURE OF DECEASED		36. SIGNATURE OF NEXT OF KIN		37. SIGNATURE OF CLERK		38. SIGNATURE OF JUDGE		39. SIGNATURE OF SHERIFF		40. SIGNATURE OF DECEASED	
41. SIGNATURE OF NEXT OF KIN		42. SIGNATURE OF CLERK		43. SIGNATURE OF JUDGE		44. SIGNATURE OF SHERIFF		45. SIGNATURE OF DECEASED		46. SIGNATURE OF NEXT OF KIN		47. SIGNATURE OF CLERK		48. SIGNATURE OF JUDGE	
49. SIGNATURE OF SHERIFF		50. SIGNATURE OF DECEASED		51. SIGNATURE OF NEXT OF KIN		52. SIGNATURE OF CLERK		53. SIGNATURE OF JUDGE		54. SIGNATURE OF SHERIFF		55. SIGNATURE OF DECEASED		56. SIGNATURE OF NEXT OF KIN	
57. SIGNATURE OF CLERK		58. SIGNATURE OF JUDGE		59. SIGNATURE OF SHERIFF		60. SIGNATURE OF DECEASED		61. SIGNATURE OF NEXT OF KIN		62. SIGNATURE OF CLERK		63. SIGNATURE OF JUDGE		64. SIGNATURE OF SHERIFF	
65. SIGNATURE OF DECEASED		66. SIGNATURE OF NEXT OF KIN		67. SIGNATURE OF CLERK		68. SIGNATURE OF JUDGE		69. SIGNATURE OF SHERIFF		70. SIGNATURE OF DECEASED		71. SIGNATURE OF NEXT OF KIN		72. SIGNATURE OF CLERK	
73. SIGNATURE OF JUDGE		74. SIGNATURE OF SHERIFF		75. SIGNATURE OF DECEASED		76. SIGNATURE OF NEXT OF KIN		77. SIGNATURE OF CLERK		78. SIGNATURE OF JUDGE		79. SIGNATURE OF SHERIFF		80. SIGNATURE OF DECEASED	
81. SIGNATURE OF NEXT OF KIN		82. SIGNATURE OF CLERK		83. SIGNATURE OF JUDGE		84. SIGNATURE OF SHERIFF		85. SIGNATURE OF DECEASED		86. SIGNATURE OF NEXT OF KIN		87. SIGNATURE OF CLERK		88. SIGNATURE OF JUDGE	
89. SIGNATURE OF SHERIFF		90. SIGNATURE OF DECEASED		91. SIGNATURE OF NEXT OF KIN		92. SIGNATURE OF CLERK		93. SIGNATURE OF JUDGE		94. SIGNATURE OF SHERIFF		95. SIGNATURE OF DECEASED		96. SIGNATURE OF NEXT OF KIN	
97. SIGNATURE OF CLERK		98. SIGNATURE OF JUDGE		99. SIGNATURE OF SHERIFF		100. SIGNATURE OF DECEASED		101. SIGNATURE OF NEXT OF KIN		102. SIGNATURE OF CLERK		103. SIGNATURE OF JUDGE		104. SIGNATURE OF SHERIFF	

BUREAU V. S.  
MAY 25 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04669

## 4697 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>A NNE ARUNDEL</b>		MARYLAND		STATE <b>MARYLAND</b>		COUNTY <b>---</b>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <b>FORT GEORGE G MEADE</b>				TOWN <b>BALTIMORE</b>		<b>3Y01-4</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location)			
<b>U S ARMY HOSPITAL</b>				<b>1016 MARKSWORTH ST.</b>			
3. NAME OF DECEASED (First) (Middle) (Last)				4. DATE OF DEATH (Month) (Day) (Year)			
<b>JESSIE N A NDERSON</b>				<b>MAY 5 19 56</b>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<b>F</b>	<b>W</b>	<b>DIVORCED</b>	<b>SEP 1896</b>	<b>59</b> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<b>HOUSEWIFE</b>		<b>NONE</b>		<b>IND IA</b>		<b>BRITISH</b>	
13. FATHER'S NAME (FIRST NAME UNKNOWN)				14. MOTHER'S MAIDEN NAME			
<b>MUNGAVEN</b>				<b>UNKNOWN</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<b>NO</b>		<b>NONE</b>		<b>1016 Marksworth St. Balto, Md. MRS SYLVIA HREBEC (Daughter)</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
420.0 IMMEDIATE CAUSE (A)				<b>ARTERIOSCLEROTIC HEART DISEASE</b>			
ANTECEDENT CAUSE(S) DUE TO				<b>With CARDIAC DECOMPENSATION</b>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<b>3 YRS</b>			
STATING UNDERLYING CAUSE LAST DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>1 MAY 1956</b> to <b>5 MAY 1956</b> , that I last saw the deceased alive on <b>5 MAY 1956</b> , and that death occurred at <b>1710 HRS</b> from the causes and on the date stated above.							
SIGNATURE <b>John F. McDonnell</b>		M.D. <b>Fort Geo. G. Meade, Maryland</b>		DATE SIGNED <b>5 MAY 1956</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<b>REMOVAL</b>		<b>7 May 1956</b>		<b>John Hopkins Medical School Anatomical Board</b>		<b>Baltimore, Md.</b>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
<b>WILLIAM L. SAYLOR, 1ST LT, MSC</b>		<b>Wm Cooke, Inc</b>		<b>Balto, Md.</b>			
DATE <b>5 May 56</b>							





1. PLACE OF DEATH a. COUNTY <b>ANNAPOLIS (ANNE ARUNDEL)</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>MARYLAND</b> b. COUNTY <b>ELVATON (ANNE ARUNDEL)</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ANNAPOLIS</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>ELVATON</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>ANNAPOLIS GENERAL HOSP.</b>				e. 15 RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <b>AUGUSTA</b> Middle <b>ARENZ</b> Last <b>ARENZ</b>		4. DATE OF DEATH Month <b>MAY</b> Day <b>15</b> Year <b>1956</b>					
5. SEX <b>FEMALE</b>	6. COLOR OR RACE <b>WHITE</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>12/3/1881</b>	9. AGE (In years last birthday) <b>74</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>HOUSE WIFE</b>			10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S. A.</b>
13. FATHER'S NAME <b>FERDINAND SCHATZ</b>				14. MOTHER'S MAIDEN NAME <b>DOROTHY YINGLING</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>NO</b>		16. SOCIAL SECURITY NO. <b>213-12-6430</b>		17. INFORMANT <b>MRS RITZ</b>		Address <b>ELVATON MARYLAND</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>multiple cerebral thromboses</b> DUE TO <b>Diabetes mellitus - severe</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <b>Hypertension</b> (b) <b>long standing</b> (c) <b>Intertrochanteric fracture of femur</b>						INTERVAL BETWEEN ONSET AND DEATH <b>6 days</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>704.0</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (If either, NAME MEDICAL EXAMINER) <b>was notified</b>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <b>Fell in her home</b>					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>April 14 1956</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Home</b>		20f. (City or town) (County) (State) <b>Elvaton Anne Arundel Md</b>	
21. I certify that I attended the deceased from <b>April 14 1956</b> to <b>May 15 1956</b> that I last saw the deceased alive on <b>May 14 1956</b> and that death occurred at <b>7:20 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Harold R. Bohman</b> M.D.				ADDRESS (Street, city or town, state) <b>May 15, 1956</b>			
DATE SIGNED <b>May 15, 1956</b>							
22a. BURIAL, CREMATION, OR REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/18/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Fordman Cemetery Md.</b>		22d. LOCATION (City, town, or county) (State) <b>Elvaton Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Charles Hill</b>				ADDRESS <b>1016 Ford Ave.</b>		24a. REC'D BY REGISTRAR DATE <b>5/17/56</b>	
				24b. REGISTRAR'S SIGNATURE <b>Wm J. French</b>			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04671

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

4671

1. PLACE OF DEATH o. COUNTY AA MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) o. STATE Md b. COUNTY AA	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) 10 Annapolis		c. LENGTH OF STAY IN 1b DOA	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION USNH, Annapolis, Md.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Reamer Middle Welker Last ARGO		4. DATE OF DEATH Month May Day 19 Year 1956	
5. SEX M	6. COLOR OR RACE Cau	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 2-29-92
9a. AGE (In years last birthday) 64 yrs.		9b. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) USA		10b. KIND OF BUSINESS OR INDUSTRY Ret	
11. BIRTHPLACE (State or foreign country) Ohio		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME James Kelly ARGO		14. MOTHER'S MAIDEN NAME Marjorie (n) MELKER	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) Yes <input checked="" type="checkbox"/> 1917-1952		16. SOCIAL SECURITY NO. U.S. Naval Hospital Records	
17. INFORMATION Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Thrombosis 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH 2 hrs	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from DOA 5-22-56, to 5-22-56, 19 56, that I last saw the deceased alive on DOA 5-22-56, 19 56, and that death occurred at 9:52p.m., from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED ACTUAL SIGNATURE R. K. MOXON CDR MC USN M.D. USNH, Annapolis, Md. 5-23-56 PHYSICIAN'S NAME (Type) R. K. MOXON CDR MC USN			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 5/23/56	
22c. NAME OF CEMETERY OR CREMATORY Arlington NAT'L		22d. LOCATION (City, town, or county) (State) Arlington Va.	
23. FUNERAL DIRECTOR'S SIGNATURE John M. Taylor & Sons Annapolis Md.		24a. REC'D BY REGISTRAR DATE 5/22/1956	
24b. REGISTRAR'S SIGNATURE			

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours of the death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

04672

Reg. Dist. No. 21

4672

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Anne Arundel</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Annapolis</b>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Homewood Convl. Home</b>				d. STREET ADDRESS <b>West Street</b>			
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
3. NAME OF DECEASED (Type or print) First Middle Last <b>KATIE IOLA BARROW Barrow</b>				4. DATE OF DEATH Month Day Year <b>MAY 17 19 56</b>			
5. SEX <b>Female</b>		6. COLOR OR RACE <b>White</b>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <b>June 16, 1868</b>	
9. AGE (In years last birthday) <b>87 yrs.</b>		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>House wife</b>				10b. KIND OF BUSINESS OR INDUSTRY <b>own home</b>		11. BIRTHPLACE (State or foreign country) <b>Anne Arundel County, Md.</b>	
12. CITIZEN OF WHAT COUNTRY? <b>USA</b>							
13. FATHER'S NAME <b>Joseph O. Fowler</b>				14. MOTHER'S MAIDEN NAME <b>Catherine Leech</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <b>none</b>		17. INFORMANT Address <b>Mr Joseph O.H. Fowler- Brother; Edgewater, Maryland</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>coronary artery disease</b> DUE TO (b) <b>thrombosis + gangrene of left foot + trunk</b> DUE TO (c) <b>generalized arteriosclerosis</b> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>420.1</b>							
INTERVAL BETWEEN ONSET AND DEATH							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>				20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <b>May 3, 1950</b> , to <b>May 17, 1956</b> , that I last saw the deceased alive on <b>May 15, 1956</b> , and that death occurred at <b>10:00 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Emily H. Wilson</b> M.D.				ADDRESS (Street, city or town, state) <b>Lothien Md.</b> DATE SIGNED <b>5-17-56</b>			
PHYSICIAN'S NAME (Type) <b>Emily H. Wilson</b>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>May 19, 1956</b>		22c. NAME OF CEMETERY OR CREMATORY <b>Edwards Chapel</b>		22d. LOCATION (City, town, or county) (State) <b>Annapolis, Maryland</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>HOPPING FUNERAL HOME</b>				ADDRESS <b>ANNAPOLIS, MARYLAND</b>		24a. REC'D BY REGISTRAR DATE <b>MAY 18, 1956</b>	
24b. REGISTRAR'S SIGNATURE <b>J. J. Brown</b>							



[5]

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. (Page 4 may be retained by hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.)

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4698

## CERTIFICATE OF DEATH

Reg. Dist. No.

04673

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Brooklyn Park</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>125 Hammonds Lane</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Franklin Lloyd Bay</u>				4. DATE OF DEATH <u>May 19</u> 19 <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 9, 1909</u>		9. AGE (In years last birthday) <u>47</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Manager</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Armour Meat Co.</u>		11. BIRTHPLACE (State or foreign country) <u>Mifflin Co., Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Frank Bay</u>				14. MOTHER'S MAIDEN NAME <u>Minnie Sankie</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.		17. INFORMANT Address <u>Mrs. Frances Murphy Bay 125 Hammonds La.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Generalized Pericarditis</u> <u>154X</u> DUE TO <u>Ca of rectum</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO _____ (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>2 years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month <u>May</u> Day <u>19</u> Year <u>1956</u> Hour <u>a. m.</u> p. m.			20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) _____ (County) _____ (State) _____
21. I certify that I attended the deceased from <u>Nov 27, 1957</u> to <u>5-19-56</u> that I last saw the deceased alive on <u>5-19-56</u> and that death occurred at <u>6:15 P.M.</u> from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>[Signature]</u> M.D.				ADDRESS (Street, city or town, state) <u>1045 Patapsco Ave. Baltimore 25, Maryland</u> DATE SIGNED <u>May 22, 1956</u>			
PHYSICIAN'S NAME (Type) <u>Henry G. Summers</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 23, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Anne Arundel Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>[Signature]</u> ADDRESS <u>BALTO. 25, MD. 4001 RITCHIE Hwy</u>				24a. REC'D BY REGISTRAR <u>[Signature]</u> DATE <u>MAY 25 1956</u>		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>	

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
 TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4699

## CERTIFICATE OF DEATH

04674

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Pasadena</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Waterford Road</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <u>Prudence</u>		First <u>Middle</u> <u>Benton</u> Last		4. DATE OF DEATH <u>May 29</u> 19 <u>56</u>		Month <u>May</u> Day <u>29</u> Year <u>1956</u>	
5. SEX <u>Female</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>April 19, 1879</u>		9. AGE (In years last birthday) <u>77</u> yrs.		
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housework</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Sheppard</u>				14. MOTHER'S MAIDEN NAME <u>Ellen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		(If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Mrs. Viva M. Heland</u> Address <u>527 Maple Ave. Brooklyn Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>260X</u> (b) <u>Diabetes mellitus</u> DUE TO (c) <u>Hypertension</u> INTERVAL BETWEEN ONSET AND DEATH <u>30 minutes</u> <u>7 years</u> <u>Not known</u>						PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>March 10</u> , 19 <u>50</u> , to <u>May 29</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 28</u> , 19 <u>56</u> , and that death occurred at <u>8:00 A.M.</u> , from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>R.M. McLaughlin</u> M.D.				ADDRESS (Street, city or town, state) <u>Pasadena, Md.</u>		DATE SIGNED <u>May 29, 1956</u>	
PHYSICIAN'S NAME (Type) <u>R.M. McLaughlin</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Meadow Top Mem Park</u>		22d. LOCATION (City, town, or county) (State) <u>Howard Co., Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>H. V. Long</u> ADDRESS <u>Glen Burnie, Md.</u>				24a. REC'D BY REGISTRAR <u>June 6, 56</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>	

CERTIFICATE OF DEATH

1956

Reg. Dist. No.

NAME OF DECEASED [Faint handwritten name]		SEX [Faint handwritten sex]		AGE [Faint handwritten age]	
DATE OF DEATH [Faint handwritten date]		PLACE OF DEATH [Faint handwritten place]		CITY [Faint handwritten city]	
TIME OF DEATH [Faint handwritten time]		CAUSE OF DEATH [Faint handwritten cause]		MANNER OF DEATH [Faint handwritten manner]	
PLACE OF BIRTH [Faint handwritten place]		DATE OF BIRTH [Faint handwritten date]		SEX [Faint handwritten sex]	
OCCUPATION [Faint handwritten occupation]		EDUCATION [Faint handwritten education]		RELIGION [Faint handwritten religion]	
MARITAL STATUS [Faint handwritten status]		PREVIOUS MARRIAGES [Faint handwritten previous marriages]		PREVIOUS DEATHS [Faint handwritten previous deaths]	
SIGNATURE OF DECEASED [Faint handwritten signature]		SIGNATURE OF WITNESS [Faint handwritten signature]		SIGNATURE OF PHYSICIAN [Faint handwritten signature]	
SIGNATURE OF CORONER [Faint handwritten signature]		SIGNATURE OF JURY [Faint handwritten signature]		SIGNATURE OF JUDGE [Faint handwritten signature]	

BUREAU V. F.

JUN 7 1956

RECEIVED



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4700

## CERTIFICATE OF DEATH

04675

28

Reg. Dist. No. ....

Item 2. Film G198 6-6-56 et

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u> COUNTY <u>Same A. A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Millersville</u>		LENGTH OF STAY (in this place) <u>2 1/2 months</u>		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>/Same Herald Harbor</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sann's Nursing Home</u>				STREET ADDRESS (If rural give location) <u>/Same North Riverside Drive</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>Mary Bethel</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>May 13th</u> 19 <u>56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Widow</u>	8. DATE OF BIRTH <u>4/2/93</u>	9. AGE last birthday <u>63</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>		11. BIRTHPLACE (State or foreign country) <u>Lynchburg, V.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Georges Christian</u>				14. MOTHER'S MAIDEN NAME <u>Florence Bell</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <u>Sann's Nursing Home Records</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
163x IMMEDIATE CAUSE (A) <u>Carcinoma of the lungs</u>						INTERVAL BETWEEN ONSET AND DEATH <u>Unknown</u>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (B) _____							
DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> et work <input type="checkbox"/> et work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>3/22/56</u> , 19____, <b>to</b> <u>5/13/56</u> , 19____, <b>that I last saw the deceased</b> <b>alive on</b> <u>5/10/56</u> , 19____, <b>and that death occurred at</b> <u>2.45 P.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Gustave H. Paubert M.D.</u> <b>ADDRESS</b> (Street, city, town, state) <u>M. D. Glen Burnie, Md.</u> <b>DATE SIGNED</b> <u>5/13/56</u>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-16-56</u>		NAME OF CEMETERY OR CREMATORY <u>Laudon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR DATE <u>5-18-56</u>		REGISTRAR'S SIGNATURE <u>K M Jager</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Detritt Donaldson Laurel, Md.</u>		ADDRESS	

# CERTIFICATE OF DEATH

Form No. 10

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. PLACE OF DEATH

9. TIME OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF FUNERAL HOME

14. SIGNATURE OF BURIAL SOCIETY

15. SIGNATURE OF OTHER

16. SIGNATURE OF OTHER

17. SIGNATURE OF OTHER

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

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26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

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31. SIGNATURE OF OTHER

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51. SIGNATURE OF OTHER

52. SIGNATURE OF OTHER

53. SIGNATURE OF OTHER

54. SIGNATURE OF OTHER

55. SIGNATURE OF OTHER

56. SIGNATURE OF OTHER

57. SIGNATURE OF OTHER

BUREAU V. S.

MAY 29 1935

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# Item 7 Filed 1975-21-55 et 4701 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04676

Reg. Dist. No. 26

1. PLACE OF DEATH o. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Maryland</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drury</u>				c. LENGTH OF STAY IN 1b			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Drury</u>				d. STREET ADDRESS <u>Drury</u>			
3. NAME OF DECEASED (Type or print) <u>CHANNEY</u> First <u>Unidentified No. 2</u> Middle <u>BIAS</u> Last				4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Colored</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Sept 12 1910</u>	
9. AGE (In years last birthday) <u>45</u> yrs.		IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Farm</u>		11. BIRTHPLACE (State or foreign country) <u>DRURY MD</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>Johy Wesley</u>				14. MOTHER'S MAIDEN NAME <u>Mary BIAS</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT <u>Irene Griffin</u> Address <u>424A WARNER ST WASHINGTON D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>981x</u> <u>Massive thoracic hemorrhage</u> DUE TO Conditions, if any, which gave rise to immediate cause (b) <u>Bullet wound of heart</u> (a), stating the underlying cause last. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot in heart during altercation.</u>			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) <u>Drury</u> (County) <u>Anne Arundel</u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>				22b. DATE THEREOF <u>May 12 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>MOSES</u>	
22d. LOCATION (City, town, or county) <u>DRURY MD</u>				(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hardisty</u>				ADDRESS <u>Glenville Md</u>		24a. REC'D BY REGISTRAR <u>5/14/1956</u>	
						24b. REGISTRAR'S SIGNATURE <u>Ada B. Lantz</u>	

RECEIVED

MAY 15 1956

BUREAU V. S.

STATE OF NEW YORK  
DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. NAME OF DECEASED: [illegible]  
2. SEX: [illegible]  
3. AGE: [illegible]  
4. DATE OF DEATH: [illegible]  
5. PLACE OF DEATH: [illegible]  
6. CAUSE OF DEATH: [illegible]  
7. MANNER OF DEATH: [illegible]  
8. SIGNATURE OF MEDICAL EXAMINER: [illegible]  
9. SIGNATURE OF WITNESS: [illegible]  
10. SIGNATURE OF CORONER: [illegible]

4702

CERTIFICATE OF DEATH

Reg. Dist. No.

25

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL Co.</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD.</u> b. COUNTY <u>AA</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN, MD</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>BROOKLYN</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>209 11th AVE.</u>				d. STREET ADDRESS <u>209 11th AVE.</u>			
3. NAME OF DECEASED (Type or print) First <u>EDNA</u> Middle <u>M.</u> Last <u>BOTELER</u>				4. DATE OF DEATH Month <u>5</u> Day <u>24</u> Year <u>1956</u>			
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>5-9-99</u>	
9. AGE (In years last birthday) <u>66</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Months Days Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>MD.</u>	
12. CITIZEN OF WHAT COUNTRY?							
13. FATHER'S NAME <u>John Miller</u>				14. MOTHER'S MAIDEN NAME <u>Sara Clark</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO.		17. INFORMANT <u>FAMILY</u> Address <u>Same</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Diabetic Acidosis</u> <u>260X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Diabetic Mellitus</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Toxic effect, possible malabsorption of calum.</u>							
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <u>Feb.</u> , 19 <u>57</u> , to <u>May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-22</u> , 19 <u>56</u> , and that death occurred at <u>8:15</u> A.M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>1101 Rockaway Ave</u> DATE SIGNED <u>H. G. Summers MD.</u>							
ACTUAL SIGNATURE <u>H. G. Summers MD.</u> M.D. <u>1101 Rockaway Ave</u>							
PHYSICIAN'S NAME (Type) <u>H. G. Summers MD.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-28-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Louden PK Cem.</u>		22d. LOCATION (City, town, or county) (State)	
23. FUNERAL DIRECTOR'S SIGNATURE <u>McCully Funeral Hm.</u> ADDRESS <u>130 E. Fort Ave</u>				24a. REC'D BY REGISTRAR DATE <u>MAY 29 1956</u>		24b. REGISTRAR'S SIGNATURE <u>John H. Hutton</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10

NAME OF DECEASED JAMES H. HARRIS		AGE 65		SEX M		RACE W		DATE OF BIRTH JAN 15 1890		PLACE OF BIRTH BALTIMORE, MD	
MANNER OF DEATH NATURAL		CAUSE OF DEATH HEART DISEASE		IMMEDIATE CAUSE CORONARY THROMBOSIS		DISEASE OR INJURY CORONARY ARTERY DISEASE		PERIOD OF ILLNESS 2 WEEKS		PLACE OF DEATH HOME	
DATE OF DEATH MAY 10 1956		TIME OF DEATH 10:30 AM		PLACE OF DEATH HOME		NAME OF PHYSICIAN DR. J. H. HARRIS		NAME OF FUNERAL HOME HARRIS FUNERAL HOME		NAME OF UNDERTAKER HARRIS FUNERAL HOME	
SIGNATURE OF PHYSICIAN J. H. HARRIS		SIGNATURE OF FUNERAL HOME HARRIS FUNERAL HOME		SIGNATURE OF UNDERTAKER HARRIS FUNERAL HOME		SIGNATURE OF DECEASED JAMES H. HARRIS		SIGNATURE OF NEXT OF KIN JAMES H. HARRIS		SIGNATURE OF WITNESSES JAMES H. HARRIS	

BUREAU V. S.

MAY 29 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this death certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy, of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4673

## CERTIFICATE OF DEATH

04678

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>309 West Street</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>HERBERT</u> <u>BRADY</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAY 28, 1956</u>			
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify)</b> <u>Married</u>	<b>8. DATE OF BIRTH</b> <u>Feb. 4, 1901</u>	<b>9. AGE last birthday</b> <u>55</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days		<b>IF UNDER 24 HRS.</b> Hours Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>County Road Dept.</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Calvert County, Md.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>no</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Mabel F. Brady- Wife- same as # 2</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>		<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<b>IMMEDIATE CAUSE (A)</b> <u>610X</u>				<u>Coronary Thrombosis</u>		<u>Immediate</u>	
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b> DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE				<u>Benign Prostatic Hypertrophy</u>		<u>1 mo.</u>	
<b>STATING UNDERLYING CAUSE LAST, DUE TO (C)</b>							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <u>5/9/56</u>		<b>19b. MAJOR FINDINGS OF OPERATION</b> <u>Prostatic Hypertrophy (Benign)</u>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b> <input type="checkbox"/>		<b>21b. PLACE (Home, farm, factory, etc.) OF INJURY</b> (street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (M.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <u>4/20/56</u> , <b>to</b> <u>5/28/56</u> , <b>that I last saw the deceased</b> <u>alive on</u> <u>5/28/56</u> , <b>and that death occurred at</b> <u>10:22 A.M.</u> , <b>from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Albert H. Anderson</u>		<b>M.D.</b>		<b>ADDRESS</b> (Street, city, town, state) <u>Annapolis, Md.</u>		<b>DATE SIGNED</b> <u>5/28/56</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>May 31, 56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Hille est Memorial Cem.</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Annapolis, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>5-31-56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>J. D. Smith</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOPPING FUNERAL HOME</u>		<b>ADDRESS</b> <u>ANNAPOLIS, MD</u>	

1991年5月

2

BUREAU V. 8.

JUN 4 1956

RECEIVED

1

## INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filled with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Items 7,11,13,14 Film G198 6-18-56 et

04679

4703

## CERTIFICATE OF DEATH

Item 2 Film G199 6-27-56 et

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Maryland</u> COUNTY <u>--</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>3 Vol-4</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Green Burmire</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>1525 W. Fayette Street</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>KAZAMAKOR CONV. HOME</u>							
<b>3. NAME OF DECEASED</b> (First) <u>John</u> (Middle) <u>BROOKS</u> (Last) <u>BROOKS</u>				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>9</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>C</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>	8. DATE OF BIRTH <u>4-11-1870</u>	9. AGE last birthday <u>85</u> yrs.	10. UNDER 1 YEAR Months Days	11. IF UNDER 24 HRS. Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)				10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>A. A. Co. Maryland</u>	
13. FATHER'S NAME <u>Unknown</u>				14. MOTHER'S MAIDEN NAME <u>Unknown</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)				16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
420.0 IMMEDIATE CAUSE (A) <u>CORONARY THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC HEART DISEASE</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION				19b. MAJOR FINDINGS OF OPERATION			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>June 1955</u> <b>to</b> <u>May 9, 1956</u> <b>that I last saw the deceased</b> <b>alive on</b> <u>May 7, 1956</u> <b>and that death occurred at</b> <u>10:30 A.M.</u> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <u>Joseph Taler</u> <b>M.D.</b> <u>Green Burmire</u> <b>ADDRESS (Street, city, town, state)</b> <u>Nid. 3-4-56</u> <b>DATE SIGNED</b>							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 12 56</u>		NAME OF CEMETERY OR CREMATORY <u>Not Auburn</u>		LOCATION (City, town, or county) (State) <u>Bata Md</u>	
24. REC'D BY REGISTRAR <u>1/14/56</u>		REGISTRAR'S SIGNATURE <u>L. J. Dyllberg</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Sarah L Brown Son</u>		ADDRESS <u>108W Montg omers Street</u>	

**CERTIFICATE OF DEATH**

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE, MD.

1. NAME OF DECEASED: [Faint text, possibly "JOHN J. SMITH"]  
2. SEX: [Faint text, possibly "M"]  
3. AGE: [Faint text, possibly "45"]  
4. DATE OF BIRTH: [Faint text, possibly "11-15-1910"]  
5. PLACE OF BIRTH: [Faint text, possibly "BALTIMORE, MD"]  
6. OCCUPATION: [Faint text, possibly "LABORER"]  
7. CAUSE OF DEATH: [Faint text, possibly "HEART DISEASE"]  
8. PLACE OF DEATH: [Faint text, possibly "HOME"]  
9. TIME OF DEATH: [Faint text, possibly "10:30 PM"]  
10. SIGNATURE OF PHYSICIAN: [Faint signature]  
11. SIGNATURE OF REGISTRAR: [Faint signature]  
12. DATE OF DEATH: [Faint text, possibly "MAY 14 1956"]

**BUREAU V. S.**

MAY 14 1956

**RECEIVED**

*[Handwritten notes and signatures at the bottom of the page]*



## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04680

4674

## CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution, residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A.</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>			c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>104 St. Washington St.</u>			d. STREET ADDRESS <u>104 St. Washington</u>		
3. NAME OF DECEASED (Type or print) First <u>Clara</u> Middle <u>M.</u> Last <u>Brown</u>			4. DATE OF DEATH Month <u>5</u> Day <u>22</u> Year <u>1956</u>		
5. SEX <u>Female</u>	6. COLOR OR RACE <u>Colored</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>9-20-1888</u>		9. AGE (In years last birthday) <u>67</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Domestic</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Home</u>	11. BIRTHPLACE (State or foreign country) <u>West River, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>Summerfield Randall</u>			14. MOTHER'S MAIDEN NAME <u>Catherine Harris</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, No, or Unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>—</u>	17. INFORMANT Address <u>Catherine Lane Annapolis, Md.</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>arterio-sclerotic Hy pertension Cardio</u> <u>443X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Heart disease</u> DUE TO (c) <u>1954</u>					
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town)	(County)	(State)
21. I certify that I attended the deceased from <u>April 15, 1954</u> to <u>May 22, 1956</u> , that I last saw the deceased alive on <u>May 22, 1956</u> , and that death occurred at <u>11:11 A.M.</u> from the causes and on the date stated above.					
ACTUAL SIGNATURE <u>R. Richardson</u>		M.D. <u>110-Clay St. Annapolis, Md.</u>		DATE SIGNED <u>5/24/56</u>	
PHYSICIAN'S NAME (Type) <u>R. Richardson. 110 Clay Street Annapolis Md.</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify)	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>Burial</u>	<u>5-25-56</u>	<u>Brewer Hill</u>		<u>Annapolis Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS		24a. REC'D BY REGISTRAR	24b. REGISTRAR'S SIGNATURE
<u>William Rose</u>		<u>Annapolis, Md.</u>		<u>5/24/56</u>	<u>Wm. J. French</u>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 18

BUREAU V. S.

MAY 24 1953

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
4794  
CERTIFICATE OF DEATH

04681

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore City</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Crownsville</u>		c. LENGTH OF STAY IN 1b <u>24 yrs. 9 mos.</u>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>		3. NAME OF DECEASED (Type or print) First Middle Last <u>William</u> <u>Brown</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Crownsville State Hospital</u>		d. STREET ADDRESS <u>Not known</u>	
4. DATE OF DEATH Month Day Year <u>5</u> <u>14</u> <u>19 56</u>		9. AGE (In years last birthday) yrs. Months Days Hours Min. <u>48</u> <u>—</u> <u>—</u> <u>—</u> <u>—</u>	
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Negro</u>	
7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>1907</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>	
11. BIRTHPLACE (State or foreign country) <u>Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S.</u>	
13. FATHER'S NAME <u>Not given</u>		14. MOTHER'S MAIDEN NAME <u>Lizzie Brown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <u>Unk.</u> <u>Unk.</u>		16. SOCIAL SECURITY NO. <u>— — —</u>	
17. INFORMANT <u>Hospital Records</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Status Epilepticus</u> <u>353.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Epilepsy</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u> <u>Lifetime</u>	
19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2,</u> 19 <u>56</u> , to <u>May 14,</u> 19 <u>56</u> , that I last saw the deceased alive on <u>May 11,</u> 19 <u>56</u> , and that death occurred at <u>1:30 a.m.</u> from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Hildegard Heard Reissmann</u> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <u>Crownsville, Md.</u> <u>5/14/56</u>	
PHYSICIAN'S NAME (Type) <u>Hildegard Heard Reissmann</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/18/56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>Crownsville State Hospital</u>		22d. LOCATION (City, town, or county) (State) <u>Crownsville</u> <u>Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Ralph H. Myers</u> ADDRESS <u>Crownsville, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 18 56</u>	
		24b. REGISTRAR'S SIGNATURE <u>H. M. Joyce</u>	

CERTIFICATE OF DEATH

1. NAME OF DECEASED		2. SEX		3. AGE	
4. PLACE OF BIRTH		5. OCCUPATION		6. MARITAL STATUS	
7. DATE OF DEATH		8. TIME OF DEATH		9. CAUSE OF DEATH	
10. PLACE OF DEATH		11. SIGNATURE OF PHYSICIAN		12. SIGNATURE OF REGISTRAR	
13. SIGNATURE OF WITNESS		14. SIGNATURE OF DECEASED		15. SIGNATURE OF NEXT OF KIN	
16. SIGNATURE OF CLERGYMAN		17. SIGNATURE OF BURIAL OFFICIAL		18. SIGNATURE OF FUNERAL HOME	
19. SIGNATURE OF CORONER		20. SIGNATURE OF JURY		21. SIGNATURE OF JUDGE	
22. SIGNATURE OF DISTRICT ATTORNEY		23. SIGNATURE OF COUNTY CLERK		24. SIGNATURE OF TOWNSHIP CLERK	
25. SIGNATURE OF VOTING CLERK		26. SIGNATURE OF POLLING CLERK		27. SIGNATURE OF CANVASSER	
28. SIGNATURE OF BALLOT BOX		29. SIGNATURE OF BALLOT		30. SIGNATURE OF BALLOT	
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RECEIVED  
JUN 1 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4705

### CERTIFICATE OF DEATH

04682

Reg. Dist. No. 26

1. PLACE OF DEATH a. COUNTY <u>a a</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broadwater, Churchton Md</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Broadwater, Churchton Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) First <u>Hoyt</u> Middle <u>Mitchell</u> Last <u>Butler JR</u>		4. DATE OF DEATH Month <u>May</u> Day <u>7</u> Year <u>1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>May 9 1925</u>
9. AGE (In years last birthday) <u>30</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Estimator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Lumber Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Washington D.C.</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>Hoyt M. Butler Sr.</u>		14. MOTHER'S MAIDEN NAME <u>Myrtle A. Carpenter</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>WW II</u>		16. SOCIAL SECURITY NO. <u>579-20-5645</u>	
17. INFORMANT <u>Henry E. Butler Sr.</u>		Address <u>2357 4th St S.W. Washington D.C.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acidosis</u> 260X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Diabetes mellitus</u> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <u>4 hrs</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>5-6</u> , 19 <u>56</u> , to <u>11 AM</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-6</u> , 19 <u>56</u> , and that death occurred at <u>11 AM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Harry N. Jones</u>		DATE SIGNED <u>7-8-56</u>	
PHYSICIAN'S NAME (Type) <u>Harry N. Jones</u>		ADDRESS (Street, city or town, state) <u>Deale Md</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>May 10 1956</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Cedar Hill Cemetery</u>	22d. LOCATION (City, town, or county) (State) <u>Smithland Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Hurdant</u>		ADDRESS <u>Salisbury Md</u>	
24a. REC'D BY REGISTRAR <u>DATE 5-10-1956</u>		24b. REGISTRAR'S SIGNATURE <u>Ada B. Smith</u>	





4675

CERTIFICATE OF DEATH

04683

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>S. Prindel Co. MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>A. A. Co</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Tracey Landing</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A. A. General Hosp.</u>				d. STREET ADDRESS <u>1</u>			
3. NAME OF DECEASED (Type or print) First <u>James</u> Middle <u>E.</u> Last <u>Butler</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>Col.</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11-12-1903</u>	
9. AGE (In years last birthday) <u>52</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>1 Laborer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>A. A. Co. Md.</u>		11. BIRTHPLACE (State or foreign country) <u>U. S. A.</u>	
13. FATHER'S NAME <u>John Butler</u>				14. MOTHER'S MAIDEN NAME <u>Ella Smith</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>				16. SOCIAL SECURITY NO. <u>217-14-6148</u>		17. INFORMANT <u>House Riggs - Tracey Landing, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>331x</u> DUE TO <u>Cerebral Hemorrhage</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO <u></u> (c) <u></u> DUE TO <u></u>				INTERVAL BETWEEN ONSET AND DEATH <u></u>			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>				19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u></u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u>	
20f. (City or town) <u></u> (County) <u></u> (State) <u></u>							
21. I certify that I attended the deceased from <u>5-22-56</u> , 19 <u>56</u> to <u>5-27-56</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-27-56</u> , 19 <u>56</u> , and that death occurred at <u>4:15</u> P. M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>A. T. Allen</u>				ADDRESS (Street, city or town, state) <u>62 CATHEDRAL ST</u>			
PHYSICIAN'S NAME (Type) <u>A. T. ALLEN</u>				DATE SIGNED <u>6-2</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-31-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u>		22d. LOCATION (City, town, or county) <u>Mc Kinshe Md</u> (State) <u>Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>William Reese II. Annapolis, Md</u>				24a. REC'D BY REGISTRAR <u>DATE 29 1956</u>			
				24b. REGISTRAR'S SIGNATURE <u>Thm J. French</u>			

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

RECEIVED

MAY 29 1956

BUREAU V. 3

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE	
CERTIFICATE OF DEATH	
1. NAME OF DECEASED	
2. SEX	
3. AGE	
4. DATE OF BIRTH	
5. PLACE OF BIRTH	
6. OCCUPATION	
7. CAUSE OF DEATH	
8. PLACE OF DEATH	
9. TIME OF DEATH	
10. SIGNATURE OF PHYSICIAN	
11. SIGNATURE OF REGISTRAR	
12. DATE OF DEATH	
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15. CAUSE OF DEATH	
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196. SIGNATURE OF PHYSICIAN	
197. SIGNATURE OF REGISTRAR	
198. DATE OF DEATH	
199. TIME OF DEATH	
200. PLACE OF DEATH	

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4706

CERTIFICATE OF DEATH

04684

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>ALLEGANY</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>VIRGINIA</u> b. COUNTY <u>FAIRFAX</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FATESVILLE</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>FALLS CHURCH</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS <u>124 WEST GEORGE MASON RD</u>			
3. NAME OF DECEASED (Type or print) First <u>HENRY</u> Middle <u>MILTON</u> Last <u>CARLSON</u>				4. DATE OF DEATH Month <u>MAY</u> Day <u>12</u> Year <u>1954</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>AUG. 8 1900</u>	
9. AGE (In years last birthday) <u>55</u> yrs.		IF UNDER 1 YEAR Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>		IF UNDER 24 HRS. Months <u>55</u> Days <u>55</u> Hours <u>55</u> Min. <u>55</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>PRESSMAN</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>PRINTER</u>		11. BIRTHPLACE (State or foreign country) <u>RIDGEWAY PA.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>							
13. FATHER'S NAME <u>OSCAR HENRY CARLSON</u>				14. MOTHER'S MAIDEN NAME <u>ELLEN OLSON</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>(If yes, give war or dates of service)</u>				16. SOCIAL SECURITY NO. <u>DORIS IRENE CARLSON</u>		17. INFORMANT <u>134 W. GEORGE MASON RD F.C. VA</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>coronary artery disease</u> DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>no</u> INTERVAL BETWEEN ONSET AND DEATH _____							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour <u>o. n.</u> <u>19</u> p. m.				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) _____ (County) _____ (State) _____							
21. I certify that I attended the deceased from <u>not in alt.</u> to _____, 19____, that I last saw the deceased alive on <u>not in alt.</u> , 19____, and that death occurred at <u>3:45 PM</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) _____ DATE SIGNED <u>10-13-54</u>							
ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. <u>Lithien Md.</u>				PHYSICIAN'S NAME (Type) <u>acting coroner</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>LAKEVIEW</u>		22d. LOCATION (City, town, or county) (State) <u>JAMESTOWN N.Y.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Bernard Harduty</u> ADDRESS <u>Salisbury</u>				24a. REC'D BY REGISTRAR <u>1954</u> DATE		24b. REGISTRAR'S SIGNATURE <u>Edward Colburn</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

11-8

NAME OF DECEASED		AGE		SEX		RACE		DATE OF BIRTH		PLACE OF BIRTH	
JAMES H. WHITE		65		M		W		JAN 15 1890		BALTIMORE, MD.	
MARRIAGE		DATE OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH		OCCUPATION	
MARRIED		JUN 10 1956		BALTIMORE, MD.		HEART DISEASE		NATURAL		LABORER	
EDUCATION		SCHOOLING		RELIGION		TENDENCY		PREVIOUS ILLNESS		HISTORY	
HIGH SCHOOL		8		METHODIST		NONE		NONE		NONE	
MILITARY SERVICE		RECORD		RECORD		RECORD		RECORD		RECORD	
NONE		NONE		NONE		NONE		NONE		NONE	
SIGNATURE OF PHYSICIAN		SIGNATURE OF REGISTRAR		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS		SIGNATURE OF WITNESS	
J. H. WHITE		J. H. WHITE		J. H. WHITE		J. H. WHITE		J. H. WHITE		J. H. WHITE	
DATE		DATE		DATE		DATE		DATE		DATE	
JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956		JUN 10 1956	

BUREAU V. 8

JUN 1 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04685

4676

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>a a</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Md</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Bay Ridge</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>U. S. General</i>		d. STREET ADDRESS <i>Lake Drive</i>	
3. NAME OF DECEASED (Type or print) First <i>William</i> Middle <i>Chappelle</i> Last <i>Chappelle</i>		4. DATE OF DEATH Month <i>5</i> - Day <i>29</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>N</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>6-4-1884</i>
9. AGE (In years last birthday) <i>71</i> yrs.		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Ret. Naval Service</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Experiment Station</i>	
11. BIRTHPLACE (State or foreign country) <i>Annapolis Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U. S. A</i>	
13. FATHER'S NAME <i>William Chappelle</i>		14. MOTHER'S MAIDEN NAME <i>Unknown</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>217-34-6640</i>	
17. INFORMANT <i>Mabel L. Chappelle</i> Address <i>(2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>610X</i> DUE TO <i>Pneumonia &amp; Paratyphoid</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Benign Prostatic Hypertrophy</i> DUE TO (c)		INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>1 mo.</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Prostatectomy 4/5/56</i>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>5/1/56</i> , 19 <i>56</i> to <i>5/29/56</i> , that I last saw the deceased alive on <i>5/29/56</i> , and that death occurred at <i>1304 M.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Albert H. Weckerm</i> M.D.		ADDRESS (Street, city or town, state) <i>Annapolis, Md</i> DATE SIGNED <i>5/29/56</i>	
PHYSICIAN'S NAME (Type) <i>Albert H. Weckerm</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>6-1-56</i>	22c. NAME OF CEMETERY OR CREMATORY <i>St Mary's</i>	22d. LOCATION (City, town, or county) (State) <i>Annapolis Md</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i> ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR <i>J. J. D. D.</i> 24b. REGISTRAR'S SIGNATURE <i>J. J. D. D.</i>	

BUREAU 4.

1956 4 JUN

RECEIVED

4797

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

## 1. PLACE OF DEATH:

COUNTY

Anne Arundel

MARYLAND

CITY (If outside corporate limits, write RURAL OR and give nearest town)

Seven, Md

LENGTH OF STAY (in this place)

HOSPITAL OR INSTITUTION OR STREET ADDRESS

Old Camp. Meade Rd

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE

Same

COUNTY

a-a.

CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN

Same

STREET ADDRESS

(If rural give location)

Same

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

FREDRICK ARNOLD CLARK

4. DATE OF DEATH:

(Month)

(Day)

(Year)

May 27 1956

## 5. SEX:

M

## 6. COLOR OR RACE:

W

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify):

married

## 8. DATE OF BIRTH:

18 December 1907

## 9. AGE last birthday:

48 yrs.

## 10. UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

Superintendent Laundry

## 10b. KIND OF BUSINESS OR INDUSTRY:

Baltimore City, Md.

## 12. CITIZEN OF WHAT COUNTRY?

yes

## 13. FATHER'S NAME:

John Clark (dec)

## 14. MOTHER'S MAIDEN NAME:

Emma Reese

## 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)

no

## 16. SOCIAL SECURITY No.:

217-05-2309

## 17. INFORMANT &amp; ADDRESS:

Mrs Emma Clark (wife) Same address.

## 18. MEDICAL CERTIFICATION

## I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Acute coronary thrombosis

Interval Between Onset And Death

2 hr

## 11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

none

## 19a. DATE OF OPERATION:

none

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

none

PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 27 May, 1956, to ....., 19....., that I last saw the deceased

alive on ....., 19....., and that death occurred at 4:20 PM, from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

H. F. Manuzak M.D.

901 Edgely Rd. Glen Burnie, MD

27 May 1956

## 23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

## DATE THEREOF

5/31/56

## NAME OF CEMETERY OR CREMATORY

Glen Haven Cemetery Anne Arundel Co, Md

## LOCATION (City, town, or county)

(State)

DATE REC'D BY LOCAL REGISTRAR

5/31/56

REGISTRAR'S SIGNATURE

L.H.

## 24. FUNERAL DIRECTOR

Wm. G. Galt, Inc. 1217 St. Paul St

Note: This patient was under the care of Dr. Sidney Scherrie of Baltis. for 6 years. He was just out of the hosp. with a heart attack. I was called by the ambulance & lower D.O.A.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

NOT A MEDICAL EXAMINER'S CASE  
*W. W. Fisher*  
M.D.  
CHIEF OR ASST. MEDICAL EXAMINER

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed to the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04687

4708

CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH a. COUNTY <b>A. A.</b> <b>MARYLAND</b>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Md.</b> b. COUNTY <b>A. A.</b>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>North Linthicum</b>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>302 Nursery Rd.</b>				d. STREET ADDRESS <b>302 Nursery Rd.</b>			
3. NAME OF DECEASED (Type or print) First <b>THERESA</b> Middle <b>R.</b> Last <b>COGLE</b>				4. DATE OF DEATH Month <b>May</b> Day <b>21</b> Year <b>19 56</b>			
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Aug. 19, 1892</b>		9. AGE (In years last birthday) <b>63</b> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>at home</b>		11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <b>Robert C. Zimmerman</b>				14. MOTHER'S MAIDEN NAME <b>Mary S. Jernosky</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16. SOCIAL SECURITY NO. <b>no</b>		17. INFORMANT <b>Mrs. Marion J. Lindauer - 302 Nursery Rd.</b>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c.)] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma cervix uteri</b> <b>171X</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Essential Hypertension</b>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)				
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>19</b>			20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>Jan 15, 1955</b> to <b>May 21, 1956</b> , that I last saw the deceased alive on <b>May 19, 1956</b> , and that death occurred at <b>7 A.M.</b> from the causes and on the date stated above.							
ACTUAL SIGNATURE <b>Robert J. Shochat</b> M.D.				ADDRESS (Street, city or town, state) <b>4111 Liberty Heights Ave</b>		DATE SIGNED <b>5/22/56</b>	
PHYSICIAN'S NAME (Type) <b>Robert J. Shochat M.D.</b>				<b>Md.</b>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		22b. DATE THEREOF <b>5/24/56</b>		22c. NAME OF CEMETERY OR CREMATORY <b>New Cathedral Cem.</b>		22d. LOCATION (City, town, or county) (State) <b>Balto., Md.</b>	
23. FUNERAL DIRECTOR'S SIGNATURE <b>Wm. F. Pickner &amp; Sons - Balto 17th</b>				24a. REC'D BY REGISTRAR DATE <b>5/3/56</b>		24b. REGISTRAR'S SIGNATURE <b>Dr. Caldwell Woodruff</b>	



# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 12

NAME OF DECEASED		DATE OF DEATH	
NORTH CAROLINA		JUNE 1, 1956	
AGE		SEX	
30		F	
RACE		EDUCATION	
W		H	
OCCUPATION		CAUSE OF DEATH	
Nurse		Heart Disease	
PLACE OF DEATH		MANNER OF DEATH	
Home		Natural	
CITY		STATE	
BALTIMORE		MD	
CITY OF DEATH		COUNTY OF DEATH	
BALTIMORE		BALTIMORE	
DATE OF BIRTH		DATE OF DEATH	
JUNE 1, 1926		JUNE 1, 1956	
PLACE OF BIRTH		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY OF BIRTH		COUNTY OF BIRTH	
BALTIMORE		BALTIMORE	
DATE OF MARRIAGE		DATE OF DEATH	
JUNE 1, 1950		JUNE 1, 1956	
PLACE OF MARRIAGE		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY OF MARRIAGE		COUNTY OF MARRIAGE	
BALTIMORE		BALTIMORE	
DATE OF INTERMENT		DATE OF DEATH	
JUNE 1, 1956		JUNE 1, 1956	
PLACE OF INTERMENT		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY OF INTERMENT		COUNTY OF INTERMENT	
BALTIMORE		BALTIMORE	
DATE OF BURIAL		DATE OF DEATH	
JUNE 1, 1956		JUNE 1, 1956	
PLACE OF BURIAL		PLACE OF DEATH	
BALTIMORE		BALTIMORE	
CITY OF BURIAL		COUNTY OF BURIAL	
BALTIMORE		BALTIMORE	

BUREAU V. 8

MAY 23 1956

RECEIVED

John F. Johnson & Son - Baltimore, Md.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)  
15M 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18  
Item 7, Film G198 6-18-56 et  
4677  
CERTIFICATE OF DEATH

04688

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Bristol</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <i>63 Anne Arundel General</i>		d. STREET ADDRESS  e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>FLORENCE</i> Middle <i>CURTIS</i> Last <i>CURTIS</i>		4. DATE OF DEATH Month <i>May</i> Day <i>3</i> Year <i>1956</i>	
5. SEX <i>Fe</i>	6. COLOR OR RACE <i>C</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>10-10-82</i>
9. AGE (In years last birthday) <i>73</i>		10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>farm laborer</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>-</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>Major Curtis</i>		14. MOTHER'S MAIDEN NAME <i>Curtis Howell</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMATION <i>A. A. Welfare Dept Records &amp; Hospital Records - A. A. Gen'l</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>332x Infarction of left Cerebral hemisphere</i> DUE TO (b) <i>260x Occlusion of left middle Cerebral Artery</i> DUE TO (c) <i>2-3 days Arteriosclerosis, generalized, severe yrs</i>		INTERVAL BETWEEN ONSET AND DEATH <i>236 hrs</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>260x Diabetes Mellitus</i>		19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>May 2, 1956</i> to <i>May 3, 1956</i> that I last saw the deceased alive on <i>May 3, 1956</i> , and that death occurred at <i>4:30 p.m.</i> from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Faye W. Allen</i> M.D.		ADDRESS (Street, city or town, state) <i>63 Cathedral St Annapolis</i> DATE SIGNED <i>5-7-56</i>	
PHYSICIAN'S NAME (Type) <i>Faye W. Allen</i>		<i>Maryland</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>May 8/56</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Coopers</i>		22d. LOCATION (City, town, or county) (State) <i>Calvert Co. Md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>J. B. Johnson</i>		ADDRESS <i>Annapolis</i>	
24a. REC'D BY REGISTRAR <i>May 10 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Thm. J. Lench</i>	

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate by signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

Item 18 Film G199 7-5-56										BALTIMORE, 18										04689									
4678										MEDICAL EXAMINER'S CERTIFICATE OF DEATH										Reg. Dist. No. 21									
1. PLACE OF DEATH a. COUNTY Anne Arundel MARYLAND										2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE Maryland b. COUNTY AA.																			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis										c. LENGTH OF STAY IN 1b										c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Annapolis									
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) (Home)										d. STREET ADDRESS 9 Steele Ave.										e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>									
2. NAME OF DECEASED (Type or print) First Samuel Middle K. Last Duvall										4. DATE OF DEATH Month May Day 2 Year 1956																			
5. SEX Male										6. COLOR OR RACE White										7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>									
8. DATE OF BIRTH Dec. 30, 1937										9. AGE (In years last birthday) 18 yrs.										IF UNDER 1 YEAR Months Days Hours Min.									
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Student										10b. KIND OF BUSINESS OR INDUSTRY Post Grad.										11. BIRTHPLACE (State or foreign country) Annapolis, Maryland									
12. CITIZEN OF WHAT COUNTRY? USA										13. FATHER'S NAME E. Saunders Duvall										14. MOTHER'S MAIDEN NAME Cecil G. Key									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no										16. SOCIAL SECURITY NO. 217-34-6277										17. INFORMANT Mr. E. Saunders Duvall- same as # 2 Address									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) No Anatomical or Chemical Cause of Death Found. 795.5 DUE TO Conditions, if any, which gave rise to immediate cause (b) (a), stating the underlying cause last. DUE TO (c)										INTERVAL BETWEEN ONSET AND DEATH																			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)										19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>																			
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.										20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)																			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19										20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>										20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)									
20f. (City or town) (County) (State)																													
21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .																													
ACTUAL SIGNATURE [Signature] M.D.										CHIEF MEDICAL EXAMINER <input type="checkbox"/>										DATE SIGNED 5/3/56									
EXAMINER'S NAME (Type) Paul F. Guerin, M.D.										ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>										DEPUTY MEDICAL EXAMINER <input type="checkbox"/>									
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial										22b. DATE THEREOF 5-5-56										22c. NAME OF CEMETERY OR CREMATORY Family Cemetery									
22d. LOCATION (City, town, or county) Forest Drive, Annapolis, Maryland										(State)																			
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS HOPE FUNERAL HOME Annapolis, Md.										24a. REC'D BY REGISTRAR DATE 5-5-56										24b. REGISTRAR'S SIGNATURE [Signature]									

BUREAU V. 5

MAY 7 1956

RECEIVED



# STATE OF MARYLAND MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04690

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b> a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> c. LENGTH OF STAY IN 1b _____ d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10</u>		<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>101 Severn Ave</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>3. NAME OF DECEASED</b> (Type or print) First <u>Robert</u> Middle <u>Lee</u> Last <u>Elles</u>		<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>6</u> Year <u>1956</u>	
<b>5. SEX</b> <u>Male</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	<b>8. DATE OF BIRTH</b> <u>Sept 13-1907</u>
<b>9. AGE</b> (In years last birthday) <u>48</u> yrs.		<b>IF UNDER 1 YEAR</b> Months _____ Days _____	<b>IF UNDER 24 HRS.</b> Hours _____ Min. _____
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Electrician</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.N. Academy</u>	
<b>11. BIRTHPLACE</b> (State or foreign country) <u>Baltimore Md</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A</u>	
<b>13. FATHER'S NAME</b> <u>Robert F. Elles</u>		<b>14. MOTHER'S MAIDEN NAME</b> <u>Mary R. Gross</u>	
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) _____ (If yes, give war or dates of service) _____		<b>16. SOCIAL SECURITY NO.</b> _____	
<b>17. INFORMANT</b> <u>Mrs George Lyker</u>		Address _____ <u>(2)</u>	
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Heart Disease</u> DUE TO (b) _____ Conditions, if any, which gave rise to immediate cause (c), stating the underlying cause last. DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____			
<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>20a. EXTERNAL CAUSE WAS PRIMARY</b> <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.)	
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>5/6</u> a. m. <u>1956</u> p. m.		<b>20d. INJURY OCCURRED</b> While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work	
<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.)		<b>20f. (City or town)</b> <u>Ades Md</u> (County) <u>Ades</u> (State) <u>Md</u>	
<b>21. I certify that I took charge of the remains described above, held an Autopsy</b> <input type="checkbox"/> <b>Inspection</b> <input type="checkbox"/> <b>Inquiry</b> <input type="checkbox"/> <b>and find that death resulted from:</b> Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/>			
<b>ACTUAL SIGNATURE</b> <u>E. L. Linhardt</u>		<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>EXAMINER'S NAME</b> (Type) <u>E. L. Linhardt</u>		<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>	
<b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>		<b>DATE SIGNED</b> <u>5/6/56</u>	
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>5-9-56</u>	
<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>Western Cem</u>		<b>22d. LOCATION</b> (City, town, or county) <u>Baltimore Md</u> (State) <u>Md</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Taylor Sons</u>		<b>24a. REC'D BY REGISTRAR</b> <u>5-8-1956</u>	
<b>ADDRESS</b> <u>Annapolis Md</u>		<b>24b. REGISTRAR'S SIGNATURE</b> <u>J. J. Daniel</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 2

MAY 10 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04691

## CERTIFICATE OF DEATH

4680

Reg. Dist. No. 21

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Annapolis</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Anne Arundel General</u>				STREET ADDRESS (If rural give location) <u>123 Spa View Ave.</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>WILLIAM</u>		(Middle) <u>F</u>		(Last) <u>FLOOD SR.</u>		(Month) <u>MAY</u> (Day) <u>29</u> (Year) <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>March 22, 1890</u>		9. AGE last birthday <u>66</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>President</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Tire Store</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>William J. Flood</u>				14. MOTHER'S MAIDEN NAME <u>Mary A. PUTNARD</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>no</u>		16. SOCIAL SECURITY NO. <u>215-28-6166</u>		17. INFORMANT & ADDRESS <u>Louise C. Flood- Wife- same as #2</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
181X IMMEDIATE CAUSE (A) <u>UREMIA</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 wks</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>PYONEPHROSIS</u>						<u>2 wks</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>CARCINOMA OF BLADDER, METASTATIC</u>						<u>18 mos</u>	
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)		20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>SEPT. 1954</u> , to <u>MAY 29, 1956</u> , that I last saw the deceased alive on <u>29 MAY, 1956</u> , and that death occurred at <u>6:54 AM</u> , from the causes and on the date stated above.							
SIGNATURE <u>Edward A. Beck</u>		DATE THEREOF <u>June 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>St. Mary's Cemetery</u>		LOCATION (City, town, or county) (State) <u>Annapolis, Maryland</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		24. REC'D BY REGISTRAR <u>U. D. D. D.</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>HOPPING FUNERAL HOME</u>		ADDRESS <u>ANNAPOLIS, MD.</u>	

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH-CALCULATED IN

DATE OF DEATH

1920

TO BE FILLED BY THE REGISTRAR OF DEATHS

NAME OF DECEASED *John William Smith*  
 SEX *Male*  
 AGE *35*  
 DATE OF BIRTH *May 15, 1885*  
 PLACE OF BIRTH *Worcester, Mass.*  
 OCCUPATION *Engineer*  
 MARITAL STATUS *Married*  
 PLACE OF DEATH *Worcester, Mass.*  
 DATE OF DEATH *May 20, 1920*

CAUSE OF DEATH *Myocardial Infarction*  
 PLACE OF INTERMENT *Worcester, Mass.*  
 NAME OF FUNERAL HOME *Worcester, Mass.*

SIGNATURE OF REGISTRAR *John W. Smith*  
 OFFICE OF THE REGISTRAR *Worcester, Mass.*

REMARKS *Myocardial Infarction*

REMARKS *Myocardial Infarction*

REMARKS *Myocardial Infarction*

REMARKS *Myocardial Infarction*

REMARKS *Myocardial Infarction*

BUREAU V. B.

JUN 4 1920

RECEIVED

RECORDED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04692

## CERTIFICATE OF DEATH

Reg. Dist. No. 51

1. PLACE OF DEATH <b>4681</b>		2. USUAL RESIDENCE (HOME) OF DECEASED	
COUNTY <b>Anne Arundel</b>	MARYLAND	STATE <b>Maryland</b>	COUNTY <b>Anne Arundel</b>
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Annapolis</b>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <b>Friendship</b>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Anne Arundel General Hospital</b>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED (Type or Print) (First) <b>MARJORIE</b> (Middle) <b>GERALDINE</b> (Last) <b>FWLER</b>		4. DATE OF DEATH (Month) (Day) (Year) <b>May 4, 19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>White</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <b>Single</b>	8. DATE OF BIRTH <b>FEB. 26, 1952</b>
9. AGE last birthday <b>4</b> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.) <b>4</b>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>none</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>none</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>USA</b>	
13. FATHER'S NAME <b>James Gardiner Fowler</b>		14. MOTHER'S MAIDEN NAME <b>Shirley Fowler</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO. <b>none</b>	
17. INFORMANT & ADDRESS <b>James Gardiner Fowler</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH <b>057.1 IMMEDIATE CAUSE (A) Meningococemia</b>		INTERVAL BETWEEN ONSET AND DEATH <b>36 Hrs</b>	
ANTECEDENT CAUSE(S) DUE TO DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e. HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <b>5/4</b> , 19 <b>56</b> , to <b>5/4</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>5/4</b> , 19 <b>56</b> , and that death occurred at <b>11 A</b> M, from the causes and on the date stated above.			
SIGNATURE <b>Philip M. Davis</b>		ADDRESS (Street, city, town, state) <b>95 Cathedral St</b>	
DATE SIGNED <b>5/4/56</b>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		DATE THEREOF <b>5/6/56</b>	
NAME OF CEMETERY OR CREMATORY <b>Mt. Harmony Cemetery</b>		LOCATION (City, town, or county) (State) <b>Owings, Maryland</b>	
24. REC'D BY REGISTRAR DATE <b>5/5/56</b>		REGISTRAR'S SIGNATURE <b>H. N. Ward</b>	
25. FUNERAL DIRECTOR'S SIGNATURE <b>W. A. Hutchins</b>		ADDRESS <b>Owings, Md</b>	



# CERTIFICATE OF DEATH

NAME OF DECEASED John Doe		AGE 45		SEX Male		RACE White	
DATE OF DEATH May 10, 1956		PLACE OF DEATH Home		CITY Baltimore		COUNTY Baltimore	
CAUSE OF DEATH Heart Disease		MANNER OF DEATH Natural		CERTIFICATE NO. 12345		REGISTRATION NO. 67890	
SIGNATURE OF DECEASED John Doe		SIGNATURE OF NEXT OF KIN Jane Doe		SIGNATURE OF PHYSICIAN Dr. Smith		SIGNATURE OF REGISTRAR Mr. Jones	
DATE OF SIGNATURE May 10, 1956		DATE OF SIGNATURE May 10, 1956		DATE OF SIGNATURE May 10, 1956		DATE OF SIGNATURE May 10, 1956	

BUREAU V. 8

MAY 8 1956

RECEIVED

NOTICE TO THE PUBLIC: This certificate is a true and correct copy of the original as filed in the office of the Registrar of the State Department of Health, Baltimore, Maryland.

4709

CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN		STREET ADDRESS (If rural give location)	
TOWN <u>Hamover</u>		<u>39 yrs</u>		TOWN <u>Hamover</u>		ADDRESS <u>Box 104A Race Road</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Box 104A Race Road</u>							
3. NAME OF DECEASED: (First) (Middle) (Last)				4. DATE (Month) (Day) (Year) OF DEATH:			
<u>Maria Antoinette Zardiner</u>				<u>May 15 1956</u>			
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED. (Specify)	8. DATE OF BIRTH:	9. AGE last birthday	IF UNDER 1 YEAR	IF UNDER 24 HRS.	
<u>Female</u>	<u>white</u>	<u>Widowed</u>	<u>Nov 15 1872</u>	<u>83</u> yrs.	Months	Days	Hours Min.
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired):		10B. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Domestic</u>		<u>Retired</u>		<u>Baltimore City</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Joshua Owens</u>				<u>Margaret Ballantine</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) If Yes, give war or dates of service				17. INFORMANT & ADDRESS:			
<u>no</u>				<u>Jerome C. Zardiner Box 104A Hamover Md</u>			
16. SOCIAL SECURITY NO.							
<u>none</u>							
18. MEDICAL CERTIFICATION							
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH							
151X							
IMMEDIATE CAUSE				(A) <u>Carcinoma of Stomach</u>			
ANTECEDENT CAUSE (S):				DUE TO <u>metastasis to Liver</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.				(B) <u>Chor Myocarditis</u>			
				DUE TO <u>arterial hypertension</u>			
				(C) <u>Senility</u>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19A. DATE OF OPERATION:				19B. MAJOR FINDINGS OF OPERATION			
<u>0</u>							
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>							
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21C. WHERE DID (City or town) (County) (State) INJURY OCCUR?			
21D. TIME (Month) (Day) (Year) (Hour) OF INJURY		21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan</u> , 1956 to <u>May 15</u> 1956 that I last saw the deceased alive on <u>May 15</u> , 1956, and that death occurred at <u>8:23</u> M, from the causes and on the date stated above.							
SIGNATURE <u>B B Brumbaugh</u>				DATE SIGNED <u>5/15/56</u>			
M.D. <u>5609 Main St</u>				ADDRESS <u>Elkridge 27 md</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>5/18/56</u>		<u>Meadowridge Mem. Pk.</u>		<u>Elkridge, Md.</u>	
DATE REC'D BY LOCAL REGISTRAR		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>May 16, 1956</u>		<u>A. W. Hedrick</u>		<u>Thos. J. Pickens &amp; Sons-Baltd</u>		<u>17</u>	

MARGIN RESERVED FOR BINDING

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

U.S. GEOLOGICAL SURVEY

U.S. GEOLOGICAL SURVEY

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## CERTIFICATE OF DEATH

Reg. Dist. No.

04694

4682

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Md.</i> b. COUNTY <i>a.c.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Colgemater</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A.C. General Hosp.</i>				e. STREET ADDRESS <i>Central Ave.</i>			
3. NAME OF DECEASED (Type or print) <i>Charles E Garton</i>				4. DATE OF DEATH <i>5-16-56</i>			
5. SEX <i>M</i>		6. COLOR OR RACE <i>W</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		8. DATE OF BIRTH <i>5-3-1920</i>	
9. AGE (In years last birthday) <i>36</i>		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Carpenter</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Construction</i>		11. BIRTHPLACE (State or foreign country) <i>Virginia</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>William Garton</i>				14. MOTHER'S MAIDEN NAME <i>Georgia Shipp</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-16-1126</i>		17. INFORMANT <i>Margaret C. Garton (2)</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Renal Insufficiency</i> DUE TO <i>Chronic Nephroses</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Nephroses</i> DUE TO <i>Old renal calculus infection</i> (c) <i>Old renal calculus infection</i>						INTERVAL BETWEEN ONSET AND DEATH <i>10 months</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I. (a) <i>Acidosis</i> (b) <i>Left Kidney previously removed</i> (c) <i>Chronic bronchitis &amp; emphysema</i>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)							
21. I certify that I attended the deceased from <i>fall</i> , 1955, to <i>16 May</i> , 1956, that I last saw the deceased alive on <i>16 May</i> , 1956, and that death occurred at <i>1:05 P.</i> M., from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>F D Hendricks</i> M.D.				ADDRESS (Street, city or town, state) <i>Shady Side, Maryland</i>			
DATE SIGNED <i>4/3/56</i>							
PHYSICIAN'S NAME (Type) <i>F D Hendricks</i>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>5-19-1956</i>		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY <i>Hillcrest Mem</i>		22d. LOCATION (City, town, or county) (State) <i>ANNAPOLIS MD.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i> ADDRESS <i>1000 Annapolis Md.</i>				24a. REC'D BY REGISTRAR <i>5/18/1956</i>		24b. REGISTRAR'S SIGNATURE <i>J. O. Daniel</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

BUREAU V. S.

MAY 21 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4210

## CERTIFICATE OF DEATH

04695

Reg. Dist. No.

1. PLACE OF DEATH o. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Churchton</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				d. STREET ADDRESS			
3. NAME OF DECEASED (Type or print) First <i>Daniel</i> Middle <i>Gray</i> Last <i>Gray</i>				4. DATE OF DEATH Month <i>5</i> Day <i>14</i> Year <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Col</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>8-1-1886</i>	9. AGE (In years lost birthday) <i>69</i> yrs.	IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, except retired) <i>Waterman Pension</i>		10b. KIND OF BUSINESS OR INDUSTRY <i>Oystering</i>		11. BIRTHPLACE (State or foreign country) <i>Churchton, md</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Benjamin Offer</i>				14. MOTHER'S MAIDEN NAME <i>Eliza Gray</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>No</i>		16. SOCIAL SECURITY NO. <i>219-12-4164</i>		17. INFORMANT Address <i>Sodoma Gray-Churchton, md</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Hemorrhage</i> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							INTERVAL BETWEEN ONSET AND DEATH <i>8 yrs</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>12-25-19</i> to <i>5-15-56</i> , that I last saw the deceased alive on <i>6-12-56</i> 19, and that death occurred at <i>6:30</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>J. T. Allen</i> M.D.				ADDRESS (Street, city or town, state) <i>62 Colchester 5-15-56</i>			
PHYSICIAN'S NAME (Type) <i>J. T. ALLEN</i>				DATE SIGNED <i>5-15-56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF <i>5-17-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Churchton, md</i>		22d. LOCATION (City, town, or county) (State) <i>Churchton, md</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>William Reese, Jr - Annapolis, Md</i> ADDRESS				24a. REC'D BY REGISTRAR <i>DATE 25 1956</i> 24b. REGISTRAR'S SIGNATURE <i>J. B. Belle Lord</i>			

CHARLES CLARK  
 CHARLES CLARK  
 CHARLES CLARK

Male Col  
 8-1-1880  
 219-12-1100  
 219-12-1100

BUREAU V. S.

MAY 25 1956

RECEIVED

CHARLES CLARK  
 CHARLES CLARK  
 CHARLES CLARK

4683

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <i>MD</i> b. COUNTY <i>AA</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>		c. LENGTH OF STAY IN 1b <i>2045</i>	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>DAVIDSONVILLE MD</i>		d. STREET ADDRESS	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>63 AA General</i>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <i>SHARON</i> First <i>JEAN</i> Middle <i>LEIFFITH</i> Last		4. DATE OF DEATH <i>MOY</i> Month <i>5</i> Day <i>1956</i> Year	
5. SEX <i>F</i>	6. COLOR OR RACE <i>W</i>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>JAN 5 1956</i>
9. AGE (In years last birthday) yrs. <i>4</i>		IF UNDER 1 YEAR Months <i>4</i> Days <i>4</i> Hours <i>4</i> Min. <i>4</i>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Canton OHIO</i>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <i>EUGENE LEIFFITH</i>		14. MOTHER'S MAIDEN NAME <i>FAYETTA HOLCOMB</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>none</i>	
17. INFORMANT <i>none</i>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>527.2</i> DUE TO <i>Bemidiosis</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Mucous plug in lungs</i> DUE TO (c) <i>none</i>			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. <i>19</i> p. m.	20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-3</i> , 19 <i>53</i> , to <i>5-5</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>5-5</i> , 19 <i>53</i> , and that death occurred at <i>11:40 PM</i> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Emily H. Lubin</i>		ADDRESS (Street, city or town, state) <i>Rothman, Md</i>	
PHYSICIAN'S NAME (Type) <i>Emily H. Lubin</i>		DATE SIGNED <i>5/5/56</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>	22b. DATE THEREOF <i>MAY 6 1956</i>	22c. NAME OF CEMETERY OR CREMATORY <i>Woodfield</i>	22d. LOCATION (City, town, or county) (State) <i>Li d / 1850 / 1850 Md.</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>TB - [Signature]</i>		ADDRESS	
24a. REC'D BY REGISTRAR <i>5/10/1956</i>		24b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: This certificate has been signed by the attending physician and completely filled in by the funeral director. Page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 14 1956

RECEIVED

## MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

4711

## CERTIFICATE OF DEATH

Reg. Dist. No. 21

Item 12 Film G199 6-22-56 et

1. PLACE OF DEATH COUNTY <u>Anne Arundel</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED STATE <u>Maryland</u> COUNTY <u>AA</u>	
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>TOWN</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>TOWN</u> <u>Sander's Park</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Sander's Park Pasadena, A. A. Co., Md.</u>		STREET ADDRESS (If rural, give location) <u>Pasadena, A. A. Co., Md.</u>	
3. NAME OF DECEASED (Type or Print)	(First) <u>John</u> (Middle) <u>Ivar</u> (Last) <u>Johanson</u>	4. DATE OF DEATH	(Month) <u>May</u> (Day) <u>5</u> (Year) <u>1956</u>
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>3/28/92</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>2 Carpenter</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Construction</u>	11. BIRTHPLACE (State or foreign country) <u>Sweden</u>
13. FATHER'S NAME <u>Unknown</u>		12. CITIZEN OF WHAT COUNTRY? <u>Unknown</u> ✓	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY No.	
17. INFORMANT AND ADDRESS <u>Mrs. Hazel Johanson Sander's Park</u>		18. MEDICAL CERTIFICATION	

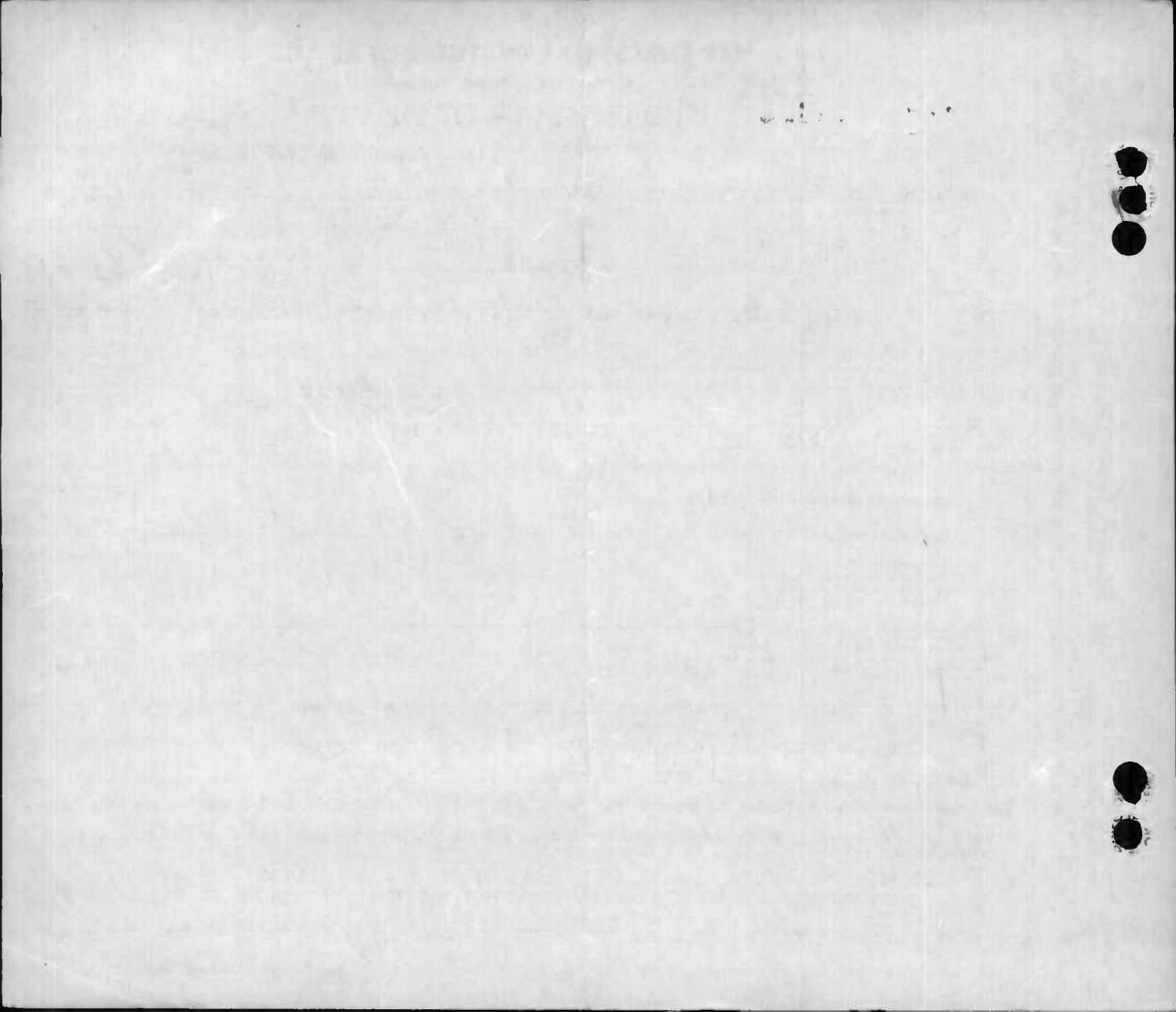
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH
Immediate cause (a) <u>Carcinoma of the right lung</u>		<u>3 months</u>
Antecedent cause(s) (b) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)		
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension, moderately severe</u>		<u>2 years</u>
19a. DATE OF OPERATION	19b. MAJOR FINDINGS OF OPERATION	20. AUTOPSY? Yes <input type="checkbox"/> No <input type="checkbox"/>
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY	(CITY OR TOWN) (COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?
22. I hereby certify that I attended the deceased from <u>May 10, 1954</u> , to <u>May 5, 1956</u> , that I last saw the deceased alive on <u>May 4, 1956</u> , and that death occurred at <u>12:45 P.M.</u> , from the causes and on the date stated above.		
SIGNATURE <u>R. M. McLaughlin</u> (Degree or title) <u>M.D.</u>		DATE SIGNED <u>May 5, 1956</u>
23. BURIAL, CREMATION REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5/8/56</u>	NAME OF CEMETERY OR CREMATORY <u>Magothy Church</u>
DATE REC'D BY LOCAL REG. <u>5-2-56</u>	REGISTRAR'S SIGNATURE	LOCATION (City, town, or county) (State) <u>Jacobsville, Md.</u>
24. FUNERAL DIRECTOR <u>John F. Denny, Inc.</u>		ADDRESS <u>715 Light St.</u>

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the cause of death clearly and legibly.





4684

## CERTIFICATE OF DEATH

Reg. Dist. No.

04698

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>A.A. GENERAL HOSP</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>WILLIAM</u> <u>KATSERELES</u>		4. DATE OF DEATH Month Day Year <u>5-</u> <u>4-</u> <u>1956</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>2-25-1889</u>
9. AGE (In years last birthday) <u>67</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>RETAIL Merchant</u>	
11. BIRTHPLACE (State or foreign country) <u>GREECE</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>CHRIS KATSERELES</u>		14. MOTHER'S MAIDEN NAME <u>Unknown</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>CHARLES KATSERELES</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Lymphatic Leukemia chronic</u> 204.0 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Hypertensive Cardio-Vascular Disease</u>			INTERVAL BETWEEN ONSET AND DEATH <u>Two weeks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>October 1955</u> to <u>May 4, 1956</u> , that I last saw the deceased alive on <u>5-4-56</u> , 19 <u>56</u> , and that death occurred at <u>5:30</u> M. from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED <u>Annapolis, Md.</u> <u>5/5/56</u>			
ACTUAL SIGNATURE <u>James R. Martin</u>		M.D. <u>Annapolis, Md.</u>	
PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-7-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>St James Greek Cem</u>	22d. LOCATION (City, town, or county) (State) <u>Parole Md</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Taylor Sons</u>		24a. REC'D BY REGISTRAR <u>5-7-1956</u>	
ADDRESS <u>Annapolis Md.</u>		24b. REGISTRAR'S SIGNATURE <u>J. Daniel</u>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

**BUREAU V. S.**

MAY 8 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04699

4712

## CERTIFICATE OF DEATH

Reg. Dist. No. 73

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>New York</u>		COUNTY <u>Sulfolk</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Linthicum Heights</u>		<u>3 mo.</u>		TOWN <u>Long Island</u>		<u>69X-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>413 Greenwood Road</u>				STREET ADDRESS (If rural give location) <u>Box 372 Elaine Road, Rocky Point</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>ROSE</u> (First) <u>-</u> (Middle) <u>KLIMA</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>May</u> (Day) <u>11</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widow</u>	<b>8. DATE OF BIRTH</b> <u>Nov. 12, 1893</u>		<b>9. AGE last birthday</b> <u>62</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Czechoslovakia</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>	
<b>13. FATHER'S NAME</b> <u>Unkown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unkown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>No</u>		<b>16. SOCIAL SECURITY NO.</b> <u>None</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mr. Walter F. Klima</u> <u>413 Greenwood Rd. Linthicum Hgts.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<u>443X</u> IMMEDIATE CAUSE (A) <u>Cardio-Vascular Disease</u>				INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Hypertension</u>				<u>5-6 yrs.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C)							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, OF INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Minute) M. <input type="checkbox"/> A. <input type="checkbox"/>		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Oct.</u>, 19<u>55</u>, to <u>May 11</u>, 19<u>56</u>, that I last saw the deceased alive on <u>May 11</u>, 19<u>56</u>, and that death occurred at <u>11:00 AM</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Chas. K. Ball Jr.</u>				<b>ADDRESS</b> (Street, city, town, state) <u>Linthicum</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>				<b>DATE SIGNED</b> <u>5/11/56</u>			
<b>24. REC'D BY REGISTRAR</b>		<b>DATE THEREOF</b> <u>May 14, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Pinelawn Nat'l Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Pinelawn, Long Island, N.Y.</u>	
<b>24. REG'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>Dr. Caldwell</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>R. V. Singleton</u>		<b>ADDRESS</b> <u>Ken Bunn, Md.</u>	
<b>DATE</b> <u>5/16/56</u>							

# CERTIFICATE OF DEATH

How Filled In

1. NAME OF DECEASED (Print or Write)

2. SEX (Male or Female)

3. AGE (Years and Months)

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION (Print or Write)

7. SEX

8. AGE

9. DATE OF BIRTH

10. PLACE OF BIRTH

11. OCCUPATION

12. SEX

13. AGE

14. DATE OF BIRTH

15. PLACE OF BIRTH

16. OCCUPATION

17. SEX

18. AGE

19. DATE OF BIRTH

20. PLACE OF BIRTH

21. OCCUPATION

22. SEX

23. AGE

24. DATE OF BIRTH

25. PLACE OF BIRTH

26. OCCUPATION

27. SEX

28. AGE

29. DATE OF BIRTH

30. PLACE OF BIRTH

31. OCCUPATION

32. SEX

33. AGE

34. DATE OF BIRTH

35. PLACE OF BIRTH

36. OCCUPATION

37. SEX

38. AGE

39. DATE OF BIRTH

40. PLACE OF BIRTH

41. OCCUPATION

42. SEX

43. AGE

BUREAU V. S.

MAY 18 1956

RECEIVED



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4685

## CERTIFICATE OF DEATH

04700

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>md</u> b. COUNTY <u>Anne Arundel</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis, Md 24 hrs.</u>				c. LENGTH OF STAY IN 1b <u>24 hrs.</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Anne Arundel General</u>				d. STREET ADDRESS <u>Gambrells Rd</u>			
3. NAME OF DECEASED (Type or print) <u>RAYMOND A</u> First <u>KNOBLE</u> Last				4. DATE OF DEATH <u>May 30</u> Month <u>19</u> Day <u>1956</u> Year			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>August 7, 1894</u>	9. AGE (In years last birthday) <u>61</u> yrs.	10. UNDER 1 YEAR <u>9</u> Months <u>23</u> Days	11. IF UNDER 24 HRS. <u>9</u> Hours <u>23</u> Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Tire Inspector</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>U S. Gov.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>George Knoble</u>				14. MOTHER'S MAIDEN NAME <u>Margaret Whitbecker</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u>		16. SOCIAL SECURITY NO. <u>218-14-3029</u>		17. INFORMANT Address <u>Mrs. Lena U. Knoble- Wife- same as # 2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute myocardial Infarct</u> DUE TO <u>420.1</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Arteriosclerotic Cardio Vascular disease</u> DUE TO (c)						INTERVAL BETWEEN ONSET AND DEATH <u>Instant</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Chronic Bronchial asthma with Chrs. Emphysema &amp; Chrs. Bronchiectasis</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)		20c. TIME OF INJURY Month, Day, Year Hour o. p. m. <u>19</u>		20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)					
21. I certify that I attended the deceased from <u>5/24</u> 19 <u>56</u> , to <u>5/30</u> 19 <u>56</u> , that I last saw the deceased alive on <u>5/30</u> 19 <u>56</u> , and that death occurred at <u>2:15 P.M.</u> from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> DATE SIGNED <u>5/30/56</u>							
ACTUAL SIGNATURE <u>Maurice Klawans</u> M.D.		PHYSICIAN'S NAME (Type) <u>MAURICIE F. KLAWANS</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>June 2, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Parkwood Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore County, Maryland</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Hopping and Kirkley Funeral Home</u> ADDRESS <u>Glen Burnie, Maryland</u>		24a. REC'D BY REGISTRAR <u>May 31, 56</u> DATE		24b. REGISTRAR'S SIGNATURE <u>[Signature]</u>			

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BUREAU V. S.

1955 4 JUN

RECEIVED

4713

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garland, P.O. Glen Burnie,</u>			c. LENGTH OF STAY IN 1b <u>3 1/2 months</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>110 First St.</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First Middle Last <u>Daniel Stanton Lawler</u>			4. DATE OF DEATH Month Day Year <u>May 3rd 1956</u>		
5. SEX <u>M.</u>	6. COLOR OR RACE <u>W.</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/30/11</u>		9. AGE (In years last birthday) <u>44</u> yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Printer</u>		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) <u>Philadelphia, Penn.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>William Lawler</u>			14. MOTHER'S MAIDEN NAME <u>Rose B. Thomas</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>213-03-3817</u>	17. INFORMANT Address <u>Mrs. Mary Lawler (wife.)</u>		
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Gunshot wound of the head</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____					INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a)					19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Shot self in head.</u>			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>5:10 p. m. 5/3 1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		20f. (City or town) (County) (State) <u>Glen Burnie Anne Arundel Md.</u>
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .					
ACTUAL SIGNATURE <u>Russell S. Fisher</u>		M.D. CHIEF MEDICAL EXAMINER <input checked="" type="checkbox"/>		DATE SIGNED <u>May 4, 1956</u>	
EXAMINER'S NAME (Type) <u>Russell S. Fisher, M.D.</u>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>5/8/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>NEW CATHEDRAL</u>	
22d. LOCATION (City, town, or county) (State) <u>EDMONSON AVE BALTO MD</u>		24. REC'D BY REGISTRAR <u>MAY 7 1956</u>			
23. FUNERAL DIRECTOR'S SIGNATURE <u>GEO. H. LEIMBACH</u>		ADDRESS <u>525 N LYNDA HURST</u>		24b. REGISTRAR'S SIGNATURE <u>L. G. Delaney</u>	

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the ward 'pending' in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BUREAU V. 8

MAY 7 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04702

## 4686 CERTIFICATE OF DEATH

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne arundel Co.</i> MARYLAND		STATE <i>Maryland</i> COUNTY <i>Prince Geo. Co.</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Bottle City, 16x2</i>		CITY (If outside corporate limits, write RURAL and give nearest town)	
TOWN <i>Annapolis</i>		LENGTH OF STAY (In this place) <i>2 days</i>		TOWN <i>Bottle City</i>		TOWN	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>anne arundel general</i>				STREET ADDRESS (If rural give location) <i>110 - Bottle Terrace</i>			
<b>3. NAME OF DECEASED</b> (First) <i>Daisy</i> (Middle) <i>Beck</i> (Last) <i>Marshall</i>				<b>4. DATE OF DEATH</b> (Month) <i>5</i> (Day) <i>29</i> (Year) <i>1956</i>			
<b>5. SEX</b> <i>Female</i>	<b>6. COLOR OR RACE</b> <i>White</i>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <i>widowed</i>	<b>8. DATE OF BIRTH</b> <i>November 27, 1874</i>	<b>9. AGE last birthday</b> <i>81</i> yrs.	<b>IF UNDER 1 YEAR</b> (Months) <i>5</i> (Days) <i>29</i>		<b>IF UNDER 24 HRS.</b> (Hours) <i>19</i> (Min.) <i>56</i>
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <i>none</i>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <i>—</i>		<b>11. BIRTHPLACE</b> (State or foreign country) <i>Halltown, West Va.</i>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <i>USA.</i>	
<b>13. FATHER'S NAME</b> <i>David Henry Beck</i>				<b>14. MOTHER'S MAIDEN NAME</b> <i>Mary Elizabeth Ruhl</i>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <i>no</i> (If Yes, give war or dates of service)		<b>16. SOCIAL SECURITY NO.</b> <i>140</i>		<b>17. INFORMANT &amp; ADDRESS</b> (Name) <i>Mrs. Mary Louis Sullivan, Soudersville</i>			
<b>18. MEDICAL CERTIFICATION</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b> <i>nd</i>	
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<b>4201 IMMEDIATE CAUSE (A)</b> <i>coronary occlusion</i>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.</b> (B) <i>coronary artery disease</i>							
<b>(C)</b>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b> <i>none</i>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE</b> (Home, farm, factory, or INJURY street, office bldg., etc.)		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21a. INJURY OCCURRED</b> White <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from</b> <i>May 26</i> , 19 <i>56</i> , to <i>May 29</i> , 19 <i>56</i> , that I last saw the deceased alive on <i>May 29</i> , 19 <i>56</i> , and that death occurred at <i>5:45 PM</i> , from the causes and on the date stated above.							
<b>SIGNATURE</b> <i>Emily H. Luben</i> M.D.				<b>ADDRESS</b> (Street, city, town, state) <i>Lathuan, Md.</i>		<b>DATE SIGNED</b> <i>5-29-56</i>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <i>BURIAL</i>		<b>DATE THEREOF</b> <i>JUNE 1, 1956</i>		<b>NAME OF CEMETERY OR CREMATORY</b> <i>FORT LINCOLN CEM.</i>		<b>LOCATION</b> (City, town, or county) (State) <i>COTTAGE CITY, MD.</i>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <i>Thm. J. French</i>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <i>Martin W. Hyson</i>		<b>ADDRESS</b> <i>Co. - Wash. D.C.</i>	
<b>DATE</b> <i>MAY 31 1956</i>							



04705

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD

# 1664 CERTIFICATE OF DEATH

1664

8-2-59

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. PLACE OF DEATH

10. DATE OF DEATH

11. TIME OF DEATH

12. SIGNATURE OF DECEASED

13. SIGNATURE OF WITNESS

14. SIGNATURE OF PHYSICIAN

15. SIGNATURE OF CORONER

16. SIGNATURE OF JURY

17. SIGNATURE OF JUDGE

18. SIGNATURE OF CLERK

19. SIGNATURE OF REGISTRAR

20. SIGNATURE OF OFFICIAL

21. SIGNATURE OF OFFICIAL

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42. SIGNATURE OF OFFICIAL

43. SIGNATURE OF OFFICIAL

*Handwritten signature*

INSTRUCTIONS

BUREAU V. S.

MAY 31 1956

RECEIVED

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04703

## 4714 CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Md.</u>		COUNTY	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Green Burmie</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		3Y01-4	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>PLAZA MARCO CONV. HOME</u>				STREET ADDRESS (If rural give location) <u>3024 Auchentorally Terrace</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>WALTER</u>		(Middle) <u>ME</u>		(Last) <u>LAURIN</u>		(Day) (Month) (Year) <u>May 4 1956</u>	
<b>5. SEX</b> <u>M</u>	<b>6. COLOR OR RACE</b> <u>C</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>2-29-1892</u>		<b>9. AGE last birthday</b> <u>64</u> yrs.	<b>IF UNDER 1 YEAR</b> (Month) (Days) (Hours) (Min.)	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>None</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Unemployed</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Louisiana</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<b>13. FATHER'S NAME</b> <u>Unknown</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT'S ADDRESS</b> <u>Mrs. Marie Moore</u> <u>3024 Auchentorally Terrace</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
<b>420.0 IMMEDIATE CAUSE (A)</b>				<u>CORONARY THROMBOSIS</u>			
<b>ANTECEDENT CAUSE(S) DUE TO (B)</b>				<u>Arteriosclerosis heart disease</u>			
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)</b>				<u>Constrictive heart failure</u>			
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>		<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>			
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)</b>			
<b>21d. TIME OF INJURY (Month) (Day) (Year) (Hour)</b>		<b>21e. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work</b>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan 27, 1956</u>, to <u>May 4, 1956</u>, that I last saw the deceased alive on <u>April 26, 1956</u>, and that death occurred at <u>5:00 P.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph Tate</u>		<b>M.D.</b> <u>Green Burmie</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Baltimore, Md.</u>		<b>DATE SIGNED</b> <u>May 4, 1956</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>May 8, 1956</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Mt. Auburn</u>		<b>LOCATION (City, town, or county) (State)</b> <u>Baltimore, Md.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>L. J. Sullivan</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Funeral Home</u> <u>1631 South Hill Ave</u>			
<b>DATE</b> <u>MAY 17 1956</u>							

01108

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18

# CERTIFICATE OF DEATH

Reg. Off. No.

1. Usual Residence of Deceased

2. Place of Death

3. Date of Death

4. Cause of Death

5. Nature of Injury

6. Date of Injury

7. Age

8. Sex

9. Occupation of Deceased

10. Name of Physician

11. Name of Hospital

12. Name of Coroner

13. Name of Registrar

14. Name of Burial Place

15. Name of Undertaker

16. Name of Funeral Home

17. Name of Cemetery

18. Name of Interment

BUREAU V. S.

MAY 17 1954

RECEIVED

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be relayed by hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4687

## CERTIFICATE OF DEATH

04704

Reg. Dist. No. 21

1. PLACE OF DEATH o. COUNTY <u>A.A</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>MARYLAND</u> b. COUNTY <u>A.A</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town.) <u>ANNAPOLIS</u>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>107 MAIN ST.</u>				d. STREET ADDRESS <u>107 MAIN ST</u>			
3. NAME OF DECEASED (Type or print) First <u>FRANK</u> Middle <u>Mileto</u> Last <u>Mileto</u>				4. DATE OF DEATH Month <u>May</u> Day <u>19</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>10/3/1882</u>	9. AGE (In years, last birthday) <u>73</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SHOE REPAIRING</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>SHOEMAKER</u>		11. BIRTHPLACE (State or foreign country) <u>ITALY</u>	12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>ANTHONY Mileto</u>				14. MOTHER'S MAIDEN NAME <u>KATHERINE SURRACI</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>—</u>		16. SOCIAL SECURITY NO. <u>—</u>		17. INFORMANT Address <u>MRS. DOMENICA Mileto #2</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>177x</u> DUE TO <u>atherosclerotic Cardiovascular disease</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Carcinoma of Prostate</u> DUE TO <u>neuro sclerosis</u> (c) <u>neuro sclerosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>3 years</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <u>2-28</u> , 19 <u>53</u> , to <u>5-19</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5-19</u> , 19 <u>56</u> , and that death occurred at <u>10:20</u> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Edith Rodler</u> M.D.				ADDRESS (Street, city or town, state) DATE SIGNED			
PHYSICIAN'S NAME (Type) <u>EDITH RODLER M.D.</u>				<u>45 FRANKLIN ST. ANNAPOLIS, MD.</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify)		22b. DATE THEREOF		22c. NAME OF CEMETERY OR CREMATORY		22d. LOCATION (City, town, or county) (State)	
<u>BURIAL</u>		<u>5/23/56</u>		<u>ST. MARYS</u>		<u>ANNAPOLIS MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE ADDRESS				24a. REC'D BY REGISTRAR		24b. REGISTRAR'S SIGNATURE	
<u>John M. Lytle &amp; Sons Annapolis, Md.</u>				DATE <u>5/21/1956</u>		<u>J. J. O'Donnell</u>	

MAY 23 1956

RECEIVED



## 4715 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <b>Anne Arundel</b>		MARYLAND		STATE <b>Md.</b>		COUNTY <b>AA</b>	
CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rivera Beach</b>		LENGTH OF STAY (in this place) <b>Yrs.</b>		CITY (If outside corporate limits, write RURAL and give nearest town) <b>Rivera Beach, Md.</b>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <b>Meadow Road</b>				STREET ADDRESS (If rural give location) <b>Meadow Rd.</b>			
3. NAME OF DECEASED (Type or Print) <b>Isabelle E. Miller</b>				4. DATE OF DEATH <b>5 27 19 56</b>			
5. SEX <b>F</b>	6. COLOR OR RACE <b>W</b>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <b>Widowed</b>	8. DATE OF BIRTH <b>10/29/1873</b>	9. AGE last birthday <b>82</b> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Housewife</b>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <b>N.Y.</b>		12. CITIZEN OF WHAT COUNTRY? <b>US</b>	
13. FATHER'S NAME				14. MOTHER'S MAIDEN NAME <b>?</b>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <b>no</b>		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS <b>Family Same</b>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
IMMEDIATE CAUSE (A) <b>422 acute pulmonary edema 2 hours</b>				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO (B) <b>Arteriosclerotic Cardiovascular disease - 20 years</b>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <b>none</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> <input type="checkbox"/>		21e. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <b>Mar. 10, 1956</b> , to <b>May 27, 1956</b> , that I last saw the deceased alive on <b>May 24, 1956</b> , and that death occurred at <b>11:30 AM</b> , from the causes and on the date stated above.							
SIGNATURE <b>R. M. McLaughlin</b>		DATE THEREOF <b>5/31/56</b>		NAME OF CEMETERY OR CREMATORY <b>Chestnut Lawn</b>		LOCATION (City, town, or county) (State) <b>Ravenna, New York</b>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <b>Burial</b>		24. REC'D BY REGISTRAR <b>L. J. DeAlby</b>		25. FUNERAL DIRECTOR'S SIGNATURE <b>McCully Funeral Home</b>		ADDRESS <b>130 E. Fort Ave.</b>	

DATE **MAY 31 1956**

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24** hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72** hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

# CERTIFICATE OF DEATH

Reg. Cert. No.

NAME OF DECEASED

John Doe

Residence

John Doe

Place of Birth

Age

John Doe

Married

Married

Occupation

Occupation

Date of Death

Place of Death

Place of Death

Sex

Sex

Family

Family

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BUREAU V. B.

MAY 31 1956

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*Handwritten signature*

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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04706

4716

## CERTIFICATE OF DEATH

Reg. Dist. No. 25

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundell</u>		STATE <u>Md</u>		COUNTY <u>Anne Arundell</u>		STATE <u>Md</u>	
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>Rural, Bosto 26</u>		LENGTH OF STAY (In this place) <u>None</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Rural, Bosto 26, and</u>		LENGTH OF STAY (In this place) <u>None</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>None</u>				STREET ADDRESS (If rural give location) <u>None</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>0114 Christopher Morck</u>				<u>May 13 1956</u>			
5. SEX <u>F</u>	6. COLOR OR RACE <u>WHITE</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>MARRIED</u>	8. DATE OF BIRTH <u>1-10-1899</u>	9. AGE last birthday <u>57</u> yrs.	10. IF UNDER 1 YEAR		11. IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Same</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY <u>U.S.A.</u>	
13. FATHER'S NAME <u>FRANK Christopher</u>				14. MOTHER'S MAIDEN NAME <u>W. BANKING</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NONE</u>		17. INFORMANT & ADDRESS <u>John C. Morck Bosto 26 Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>15. MEDICAL CERTIFICATION</b>			
260X IMMEDIATE CAUSE (A) <u>Respiratory Failure</u>				INTERVAL BETWEEN ONSET AND DEATH <u>30 min</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>Coronary Thrombosis</u>				<u>1 hr.</u>			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) <u>Diabetes Mellitus</u>				<u>15 yrs</u>			
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>Pneumatoid Arthritis</u>				<u>8 mos</u>			
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> White at work <input checked="" type="checkbox"/> Not white at work <input type="checkbox"/>		21e. INJURY OCCURRED		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>10/12</u> , 19 <u>47</u> , to <u>5/12</u> , 19 <u>56</u> that I last saw the deceased alive on <u>5/11</u> , 19 <u>56</u> , and that death occurred at <u>1:00 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>R.W. Richard</u> M.D.				DATE SIGNED <u>5/13/56</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>5-15-56</u>		NAME OF CEMETERY OR CREMATORY <u>EAST NEW MARKET CEM.</u>		LOCATION (City, town, or county) (State) <u>Dorchester, Co. Md.</u>	
24. REC'D BY REGISTRAR <u>W.H.G.</u>		REGISTRAR'S SIGNATURE <u>John Whitson</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Mc Cully Fun. Hm.</u>		ADDRESS <u>130 E. Fort Ave.</u>	



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by me in the presence of the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4688

## CERTIFICATE OF DEATH

04707

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>aa</u> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> c. LENGTH OF STAY IN 1b <u></u> d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.C. General Hospital</u>		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Md</u> b. COUNTY <u>aa</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>St Margarets</u> d. STREET ADDRESS <u></u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Thomas Wesley Morton Jr.</u> First Middle Last 4. DATE OF DEATH <u>5-27-1956</u> Month Day Year		5. SEX <u>Male</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> 8. DATE OF BIRTH <u>6-11-1892</u> 9. AGE (In years last birthday) <u>63</u> yrs. 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Dairy Farmer</u> 11. BIRTHPLACE (State or foreign country) <u>Brandyswine Va</u> 12. CITIZEN OF WHAT COUNTRY? <u>U. S. A</u>	
13. FATHER'S NAME <u>Thomas W. Morton Sr.</u> 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>yes</u> (If yes, give war, or dates of service) <u>World War I</u> 16. SOCIAL SECURITY NO. <u></u> 17. INFORMANT <u>Lena B. Morton</u> Address <u>(2)</u>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>154X</u> DUE TO <u>Uremia</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hydronephrosis Bilateral</u> DUE TO <u>Carcinoma of Rectum</u> (c) <u></u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u> INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>6 months</u> <u>2 yrs.</u>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u></u> 20f. (City or town) (County) (State)		21. I certify that I attended the deceased from <u>Jan 1954</u> , 19 <u>54</u> , to <u>May 27</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 27</u> , 19 <u>56</u> , and that death occurred at <u>11:55</u> PM from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Annapolis, Md</u> DATE SIGNED <u>5/28/56</u>	
ACTUAL SIGNATURE <u>James R. Martin</u> PHYSICIAN'S NAME (Type) <u>JAMES R. MARTIN</u>		22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> 22b. DATE THEREOF <u>5/31/56</u> 22c. NAME OF CEMETERY OR CREMATORY <u>Annapolis Nat'l</u> 22d. LOCATION (City, town, or county) (State) <u>Annapolis Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor &amp; Sons</u> ADDRESS <u>Annapolis, Md.</u>		24a. REC'D BY REGISTRAR <u></u> DATE <u>6/1/56</u> 24b. REGISTRAR'S SIGNATURE <u>V. Ormoch</u>	





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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04708

4717

## CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>A.A. CO. FREETOWN</u> MARYLAND				STATE <u>MARYLAND</u> COUNTY <u>A.A.</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Free Town</u> 1 MO				CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>FREETOWN, Md</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>FREETOWN, Md.</u>				STREET ADDRESS (If rural give location) <u>GLEN BURNIE</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>PAMELA MARIE PARKER</u>				<b>4. DATE OF DEATH</b> (Month) <u>5</u> (Day) <u>29</u> (Year) <u>1956</u>			
<b>5. SEX</b> <u>F</u>	<b>6. COLOR OR RACE</b> <u>E</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>INFANT</u>	<b>8. DATE OF BIRTH</b> <u>APRIL 30, 1954</u>		<b>9. AGE last birthday</b> yrs. <u>2</u>	<b>IF UNDER 1 YEAR</b> Months <u>29</u> Days <u>29</u>	<b>IF UNDER 24 HRS.</b> Hours <u>29</u> Min.
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>NONE</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>HOPKINS HOS. BALTO. MD.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.</u>	
<b>13. FATHER'S NAME</b> <u>ROLAND PARKER</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>DORIS GREEN</u>			
<b>15. WAS DECEASED EVER IN U.S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b> <u>337 EDNA KANE PASADENA, MD.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>491X</b> IMMEDIATE CAUSE (A) <u>Acute broncho pneumonia</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b> <u>none</u>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While <input type="checkbox"/> Not while <input type="checkbox"/> M. et work <input type="checkbox"/> et work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 2, 1956, to May 29, 1956, that I last saw the deceased alive on May 28, 1956, and that death occurred at Noon, M., from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>R. M. McLaughlin</u>				<b>ADDRESS</b> (Street, city, town, state) <u>M.D. Pasadena, Md.</u>		<b>DATE SIGNED</b> <u>May 29, 1956</u>	
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>BURIAL</u>		<b>DATE THEREOF</b> <u>5-30-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>MAGOTHY CEM.</u>		<b>LOCATION (City, town, or county)</b> <u>MAGOTHY, MD.</u>	
<b>24. REC'D BY REGISTRAR</b>		<b>REGISTRAR'S SIGNATURE</b> <u>L. J. Dealy</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>WM. A. JACKSON FUNERAL HOME INC.</u>		<b>ADDRESS</b> <u>916 PENNSYLVANIA AVE.</u>	
<b>DATE</b> <u>JUN 1 1956</u>							

CERTIFICATE OF DEATH

See Ord. No.

1. HOUSE NUMBER, STREET, CITY OR VILLAGE

1. J. J. FOSTER

1 M

PAMELA MARIE PARKER

Infant April 20 1956

Infant of Mr. PARKER

MRS. GREEN

EDMUND PARKER

BUREAU 118

JUN 1 1956

RECEIVED

W. H. TAYLOR, JR.  
J. J. FOSTER

4689

## CERTIFICATE OF DEATH

04709

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institutional, residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>A.A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>63 U.S. General Hospital</i>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>NELLIE</i> Middle <i>M.</i> Last <i>PATTERSON</i>				4. DATE OF DEATH Month <i>MAY</i> Day <i>5</i> Year <i>1956</i>			
5. SEX <i>Female</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Aug 23-1875</i>	
9. AGE (In years last birthday) <i>80</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>		11. BIRTHPLACE (State or foreign country) <i>Baltimore Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>James Monaghan</i>				14. MOTHER'S MAIDEN NAME <i>Katherine Stangmeyer</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>		17. INFORMANT <i>May Emerson R. Johnson</i> Address			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Cerebral Vascular Accident</i> 443X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Hypertensive Cardiovascular Disease</i> DUE TO (c) <i>unknown</i>						INTERVAL BETWEEN ONSET AND DEATH <i>15 DAYS</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
20f. (City or town) (County) (State)				20g. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>December 1954</i> , to <i>5 May 1956</i> , that I last saw the deceased alive on <i>5 May 1956</i> , and that death occurred at <i>9:15 P.M.</i> from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>Edward S. Beck</i>				ADDRESS (Street, city or town, state) <i>41 Southgate Ave Annapolis Md.</i>			
DATE SIGNED <i>5/10/56</i>				DATE SIGNED <i>5/10/56</i>			
PHYSICIAN'S NAME (Type) <i>EDWARD S. BECK</i>				DATE SIGNED <i>5/10/56</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-9-1956</i>		22c. NAME OF CEMETERY OR CREMATORY <i>St. Mary's Cem.</i>		22d. LOCATION (City, town, or county) (State) <i>Annapolis Maryland</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Son</i>				24a. REC'D BY REGISTRAR <i>5/10/1956</i>			
ADDRESS <i>Annapolis Md</i>				24b. REGISTRAR'S SIGNATURE <i>J. J. ...</i>			

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

Form with multiple sections for recording death information, including fields for name, date, time, place, cause, and medical history. The form is oriented horizontally but contains vertical text labels for various fields.

BUREAU V. S.

MAY 14 1956

RECEIVED



## 4718 CERTIFICATE OF DEATH

Reg. Dist. No. ....

## I. PLACE OF DEATH:

COUNTY Anne Arundel MARYLAND  
 CITY (If outside corporate limits, write RURAL OR and give nearest town) Glenn Burnie LENGTH OF STAY (in this place) 7 1/2 mo  
 TOWN Glenn Burnie  
 HOSPITAL OR INSTITUTION OR STREET ADDRESS Plaza Manor Nursing Home Box 376-A Rt 3

## 2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Maryland COUNTY Baltimore  
 CITY (If outside corporate limits, write RURAL and give nearest town) Baltimore TOWN 3rd  
 STREET ADDRESS (If rural give location) 2 N. Bentall St.

## 3. NAME OF DECEASED:

(First)

(Middle)

(Last)

(Type or Print)

RICHARD

PAULEY

## 4. DATE OF DEATH:

(Month)

(Day)

(Year)

May

24

19 56

## 5. SEX:

## 6. COLOR OR RACE:

## 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):

## 8. DATE OF BIRTH:

## 9. AGE last birthday:

IF UNDER 1 YEAR IF UNDER 24 HRS.

M

col

Widowed Jan 13, 1893

63 yrs.

Months

Days

Hours

Min.

## 10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired):

## 10b. KIND OF BUSINESS OR INDUSTRY:

## 11. BIRTHPLACE (State or foreign country):

## 12. CITIZEN OF WHAT COUNTRY?

shipbuilder Dry Dock

Myrtlewood Ala.

## 13. FATHER'S NAME:

## 14. MOTHER'S MAIDEN NAME:

Jesse Pauley

Rachael Gullett

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (if Yes, give war or dates of service)

## 16. SOCIAL SECURITY No.:

## 17. INFORMANT &amp; ADDRESS:

2 N. Bentall St.

No

Eloise Williams

## 18. MEDICAL CERTIFICATION

## 1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

331X

Immediate cause

(a)

DUE TO

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Cerebral vascular accident

Hypertension

Interval Between Onset And Death

1 day

5 yrs

## II. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

Arteriosclerotic Heart Disease

5 yrs

## 19a. DATE OF OPERATION:

## 19b. MAJOR FINDINGS OF OPERATION

## 20. AUTOPSY?

Yes ☐ No ☒

## 21. ACCIDENT SUICIDE HOMICIDE

(Specify)

## PLACE (Home, farm, factory, street, office bldg., etc.) OF INJURY

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

## HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from 17 May, 1956, to present, 1956, that I last saw the deceased

alive on 17 May, 1956, and that death occurred at 1:45 PM, from the causes and on the date stated above.

SIGNATURE H.F. Manzyak M.D.

(Degree or title)

ADDRESS 901 Edgely Rd, Glenn Burnie, Md. DATE SIGNED 24 May 1956

## 23. BURIAL, CREMATION, REMOVAL (Specify)

## DATE THEREOF

## NAME OF CEMETERY OR CREMATORY

## LOCATION (City, town, or county)

(State)

## DATE REC'D BY LOCAL REGISTRAR

## REGISTRAR'S SIGNATURE

## 24. FUNERAL DIRECTOR

## ADDRESS

Note: This is a regular pt. of Dr. J. J. Taler. I was called to pronounce him dead when Dr. Taler was out of town.

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/15/19

8174



*Handwritten signature or initials.*

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4690 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04711

Reg. Dist. No. 21

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Ad</u> <b>MARYLAND</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> c. LENGTH OF STAY in 1b d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>10</u>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If Institution: Residence before admission) a. STATE <u>md</u> b. COUNTY <u>Ad</u> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u> d. STREET ADDRESS <u>1000 Madison St</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>											
<b>3. NAME OF DECEASED</b> (Type or print) <u>EILER</u> First <u>M. PETERSON</u> Middle Last				<b>4. DATE OF DEATH</b> Month <u>5</u> Day <u>5</u> Year <u>1956</u>											
<b>5. SEX</b> <u>Male</u>		<b>6. COLOR OR RACE</b> <u>White</u>		<b>7. MARRIED</b> <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>7-7-1887</u>		<b>9. AGE</b> (in years last birthday) <u>72</u> yrs.		<b>IF UNDER 1 YEAR</b> Months <u>  </u> Days <u>  </u>		<b>IF UNDER 24 HRS.</b> Hours <u>  </u> Min. <u>  </u>			
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>2 Ret Bandmaster</u>				<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>U.S.A. Band</u>				<b>11. BIRTHPLACE</b> (State or foreign country) <u>Denmark</u>				<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>U.S.A.</u>			
<b>13. FATHER'S NAME</b> <u>Unknown</u>						<b>14. MOTHER'S MAIDEN NAME</b> <u>Unknown</u>									
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown)				<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Joseph Russell</u> Address <u>(E)</u>							
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c)] <b>PART I. DEATH WAS CAUSED BY:</b> IMMEDIATE CAUSE (a) <u>976X</u> <u>Gunshot wound skull</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u>												<b>INTERVAL BETWEEN ONSET AND DEATH</b> <u>sudden</u>			
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>														<b>19. WAS AUTOPSY PERFORMED?</b> YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
<b>20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.</b>						<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Suicide</u>									
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour <u>4</u> a. m. <u>5/5</u> 19 <u>56</u> p. m.						<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Street</u>				<b>20f. (City or town)</b> <u>Annapolis</u> (County) <u>Ad</u> (State) <u>MD</u>			
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input checked="" type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/>															
<b>ACTUAL SIGNATURE</b> <u>E. Linhardt</u>						<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/>						<b>DATE SIGNED</b> <u>5/8/56</u>			
<b>EXAMINER'S NAME</b> (Type) <u>E. Linhardt</u>						<b>ASSISTANT MEDICAL EXAMINER</b> <input type="checkbox"/>									
						<b>DEPUTY MEDICAL EXAMINER</b> <input checked="" type="checkbox"/>									
<b>22a. BURIAL, CREMATION, REMOVAL</b> (Specify) <u>Burial</u>				<b>22b. DATE THEREOF</b> <u>5-9-56</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>St. Annes Cem</u>				<b>22d. LOCATION</b> (City, town, or county) <u>Annapolis</u> (State) <u>md</u>					
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>John M. Saylor</u> ADDRESS <u>Annapolis Md</u>						<b>24a. REC'D BY REGISTRAR</b> <u>5-8-1956</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>V. J. Russell</u>					

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate indicating the ward "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON 12  
12 BY MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(5)  
SM 9/55

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4719 MEDICAL EXAMINER'S CERTIFICATE OF DEATH  
Item 14, Film G198 6-14-56 et

04712

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>St. Margaret, P.O. Annapolis</b> c. LENGTH OF STAY IN lb <b>Few seconds</b> d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>Revell Boulevard</b>		2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore</b> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>29</b> d. STREET ADDRESS <b>419 Rosecroft Terrace</b> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <b>Carroll Ray Phillipps</b> First Middle Last		4. DATE OF DEATH <b>May 30th.</b> Month Day Year <b>19 56</b>	
5. SEX <b>Male</b>	6. COLOR OR RACE <b>W</b>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>4/15/95</b>
9. AGE (In years last birthday) <b>61</b> yrs.		IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Hearing Aid Consultant at Sears &amp; Roebuck</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Wilcomb Co. Md.</b>	
11. BIRTHPLACE (State or foreign country) <b>U.S.A.</b>		12. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	
13. FATHER'S NAME <b>Ross Phillips</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) <b>Yes World War # 1</b>		16. SOCIAL SECURITY NO. <b>216-07-9679</b>	
17. INFORMANT <b>Mrs. Theresa L. Hartman, (daughter)</b>		Address <b>(deceased.) Same address as</b>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Fracture of skull, of right leg, of neck and</b> <b>823X</b> DUE TO Conditions, if any, which gave rise to immediate cause (b) <b>crushed chest.</b> (a), stating the underlying cause lost. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <b>Automobile hit a tree.</b>			INTERVAL BETWEEN ONSET AND DEATH <b>Sudden</b>
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <b>6:19 5/30/56 19</b>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <b>Revell Highway</b>		20f. (City or town) (County) (State) <b>St. Margaret, A.A. Md.</b>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .			
ACTUAL SIGNATURE <b>Gustave H. Faubert</b>		DATE SIGNED <b>5/30/56</b>	
EXAMINER'S NAME (Type) <b>Gustave H. Faubert M.D.</b>		CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	22b. DATE THEREOF <b>6/4/56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>U.S. National</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>Mundt &amp; Son Catonsville</b>		24a. REC'D BY REGISTRAR <b>5/4/56</b>	
ADDRESS		24b. REGISTRAR'S SIGNATURE <b>N. J. French</b>	



STATE OF TEXAS  
COUNTY OF DALLAS

BUREAU V. B.

JUN 4 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, indicating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of the Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4720

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04713

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission) a. STATE <u>Md.</u> b. COUNTY <u>AA</u>				
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Arnold</u>			c. LENGTH OF STAY IN 1b <u>Few minutes</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u> 10			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Country Rd.</u>				d. STREET ADDRESS <u>101 Cheaseapeake Ave</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Charles Edward</u> Middle <u>Reckner</u> Last <u>Reckner</u>				4. DATE OF DEATH Month <u>May</u> Day <u>12</u> Year <u>19 56</u>				
5. SEX <u>Male</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/7/41</u>		
9. AGE (In years last birthday) <u>14 yrs.</u>		IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>				
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Student</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>School</u>		11. BIRTHPLACE (State or foreign country) <u>Annapolis, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Eugene Dewey Reckner</u>				14. MOTHER'S MAIDEN NAME <u>Ruth Carroll</u>				
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO. (If yes, give war or dates of service)		17. INFORMANT Address <u>Mrs Ruth Reckner, same as 2</u>				
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of Skull , Fracture of Neck</u> 825X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>  </u> DUE TO (c) <u>  </u> INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u> 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>								
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Automobile Accident</u>						
20c. TIME OF INJURY Month, Day, Year Hour <u>5.15</u> o. m. <u>5/12</u> p. m. <u>1956</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Same as death</u>		20f. (City or town) (County) (State) <u>Arnold</u> <u>AA</u> <u>Md.</u>		
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .								
ACTUAL SIGNATURE <u>Gustave H. Faybert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				
EXAMINER'S NAME (Type) <u>Gustave H. Faybert</u>				ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>				
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> 5/12/56				
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5-15-56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Hellercrest</u>		22d. LOCATION (City, town, or county) (State) <u>Annapolis</u> <u>md</u>		
23. FUNERAL DIRECTOR'S SIGNATURE <u>Gordon M. Taylor Sons</u>				ADDRESS <u>Annapolis Md.</u>		24a. REC'D BY REGISTRAR DATE <u>5/15/1956</u>		
				24b. REGISTRAR'S SIGNATURE <u>J. J. Daniel</u>				

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 15  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 16 1956  
BUREAU V. 5

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4721

## CERTIFICATE OF DEATH

04714

Reg. Dist. No. 2

1. PLACE OF DEATH a. COUNTY <i>Anne Arundel</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Maryland</i> b. COUNTY <i>Anne Arundel</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis Roads</i>		c. LENGTH OF STAY IN 1b <i>Rural Annapolis</i>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <i>MARIE</i> Middle <i>REILEY</i> Last <i>REILEY</i>		4. DATE OF DEATH Month <i>MAY</i> Day <i>9</i> Year <i>1956</i>	
5. SEX <i>Female</i>	6. COLOR OR RACE <i>White</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>MAY 27-1897</i>
9. AGE (In years last birthday) <i>58</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Housewife</i>	
11. BIRTHPLACE (State or foreign country) <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Charles E. Parks</i>		14. MOTHER'S MAIDEN NAME <i>Katherine E. Scherder</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i>		16. SOCIAL SECURITY NO. <i>no</i>	
17. INFORMANT <i>Mrs. George C. Reich (#2)</i>		18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>coronary heart disease</i> <i>260X</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>diabetes mellitus</i> (c) <i>rheumatoid arthritis</i>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		INTERVAL BETWEEN ONSET AND DEATH <i>15 years</i>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>4-16</i> 19 <i>54</i> to <i>5-9</i> 19 <i>56</i> , that I last saw the deceased alive on <i>5-8</i> 19 <i>56</i> , and that death occurred at <i>10:30</i> A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>Smith Rodler M.D.</i>		ADDRESS (Street, city or town, state) <i>45 Franklin St. Annapolis, Md.</i>	
DATE SIGNED <i>5-11-1956</i>		DATE SIGNED	
PHYSICIAN'S NAME (Type) <i>EDITH RODLER M.D.</i>		DATE SIGNED	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>5-12-1956</i>	
22c. NAME OF CEMETERY OR CREMATORY <i>Holy Cross</i>		22d. LOCATION (City, town, or county) (State) <i>Baltimore Md.</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor</i>		24a. REC'D BY REGISTRAR <i>5/11/1956</i>	
ADDRESS <i>San Annapolis Md.</i>		24b. REGISTRAR'S SIGNATURE <i>J. J. U. Branch</i>	

BUREAU T. J.

MAY 14 1956

REF



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

4691

## CERTIFICATE OF DEATH

04715

Reg. Dist. No. 2

1. PLACE OF DEATH o. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE <u>Md</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>	c. LENGTH OF STAY IN 1b	c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis Md</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>U.S. General</u>		d. STREET ADDRESS <u>11 Baldrige Rd.</u>	
3. NAME OF DECEASED (Type or print) First <u>Donald</u> Middle <u>Fay</u> Last <u>Ressler</u>		4. DATE OF DEATH Month <u>5</u> Day <u>6</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12-20-1955</u>
9. AGE (In years last birthday) <u>1</u> yrs.		IF UNDER 1 YEAR Months <u>4</u> Days <u>16</u>	IF UNDER 24 HRS. Hours <u></u> Min. <u></u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>none</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>none</u>	11. BIRTHPLACE (State or foreign country) <u>Annapolis Md</u>
12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>		13. FATHER'S NAME <u>Donald F. Ressler</u>	
14. MOTHER'S MAIDEN NAME <u>Melva L. Hontz</u>		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>	
16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>Donald F. Ressler</u> Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Neuroblastoma of Testis</u> DUE TO 193X Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u></u> DUE TO (c) <u></u>			INTERVAL BETWEEN ONSET AND DEATH <u>4-5 wks</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. n. p. m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <u>BIRTH</u> , 19 <u>56</u> , to <u>5/6</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>5/6/56</u> , 19 <u>56</u> , and that death occurred at <u>7:30</u> M., from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Philip Brisue</u>		ADDRESS (Street, city or town, state) <u>95 Calverton St. ANNAPOLIS</u>	
PHYSICIAN'S NAME (Type) <u>PHILIP BRISUE</u>		DATE SIGNED <u>5/2/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	22b. DATE THEREOF <u>5-8-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>Calverton</u>	22d. LOCATION (City, town, or county) (State) <u>Pa</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John W. Fay Jr</u>		ADDRESS <u>Annapolis Md</u>	
24a. REC'D BY REGISTRAR DATE <u>5/8/1956</u>		24b. REGISTRAR'S SIGNATURE <u>J. J. O'Donnell</u>	

BUREAU V. S.

MAY 10 1956

RECEIVED

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Office of Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation or removal.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04716

4722

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY <u>Same</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>		c. LENGTH OF STAY IN 1b <u>7 1/2 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>523 Westway, Harundale</u>				d. STREET ADDRESS <u>Same</u>			
3. NAME OF DECEASED (Type or print) First <u>John</u> Middle <u>Geiger</u> Last <u>Rhoads</u>				4. DATE OF DEATH Month <u>May</u> Day <u>28th</u> Year <u>19 56</u>			
5. SEX <u>M.</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>11/7/1900</u>		9. AGE (In years last birthday) <u>55</u> yrs.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Plumber</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Reading, Pa.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Glanston Rhoads</u>				14. MOTHER'S MAIDEN NAME <u>Lillian Geiger</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>Yes</u>		16. SOCIAL SECURITY NO. <u>221-07-1688</u>		17. INFORMANT Address <u>Mrs. Sylvia Rhoads, (Wife).</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral Hemorrhage, caused by a self inflicted</u> 976x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>wound with a rifle gauge # 22.</u> DUE TO (c) <u>Sudden</u>							INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>The shooting of a bullet Gauge 22, through the mouth.</u>					
20c. TIME OF INJURY Hour <u>6.50</u> o. m. <u>5/28/56</u> p. m. <u>19</u>		20d. INJURY OCCURRED White <input type="checkbox"/> Not white <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>In bed room at home, Glen Burnie, A.A., Md.</u>		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Gustave H. Faubert, M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>May 29th, 1956.</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>June 1, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Arlington NAT.</u>		22d. LOCATION (City, town, or county) (State) <u>Arlington, VA.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>James H. Turley</u>		ADDRESS <u>421 Eastern Highway, Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR <u>L. J. Seelby</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. Seelby</u>	

# STATE OF NEW YORK DEPARTMENT OF HEALTH BUREAU OF VITAL STATISTICS MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. 8

JUN 1 1956

RECEIVED

1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 72 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04717

4723

## CERTIFICATE OF DEATH

Reg. Dist. No. 22

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>ANNE ARUNDEL</u>		STATE <u>Md</u>		COUNTY <u>WACO</u>			
CITY (If outside corporate limits, write RURAL and give nearest town) <u>RURAL, SEVERN</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Severn</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>GAMBRILLS ROAD</u>				STREET ADDRESS (If rural give location) <u>Gambrells Rd</u>			
<b>3. NAME OF DECEASED</b> (Type or Print) <u>FREDERICK</u> (First) <u>J</u> (Middle) <u>RIES</u> (Last)				<b>4. DATE OF DEATH</b> (Month) <u>MAY</u> (Day) <u>15</u> (Year) <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH <u>Sept 18, 1877</u>	9. AGE last birthday <u>78</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if foreign) <u>Boat Tender</u>		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country) <u>Phil PENNA</u>		12. CITIZEN OF WHAT COUNTRY?	
13. FATHER'S NAME <u>ELKHART E RIES</u>				14. MOTHER'S MAIDEN NAME <u>WILHELMINA SCHNEIDER</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO. <u>18-19-5812</u>		17. INFORMANT & ADDRESS <u>BURDETTE RIES SEVERN Md</u>			
<b>I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
332X IMMEDIATE CAUSE (A) <u>CEREBRAL THROMBOSIS</u>				INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>			
ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROSIS, GENERAL</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO (C)							
STATING UNDERLYING CAUSE LAST.							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION <u>None</u>		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <u>NOVEMBER 1954</u> , to <u>MAY 15, 1956</u> , that I last saw the deceased alive on <u>MAY 14, 1956</u> , and that death occurred at <u>5 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Betty L. Jones</u>				ADDRESS (Street, city, town, state) <u>M.D. 104 Clain House, 51st St, 51st St</u>		DATE SIGNED	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>May 18 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Horseshoe Cem</u>		LOCATION (City, town, or county) (State) <u>Woodlawn Md</u>	
24. REC'D BY REGISTRAR <u>MAY 17 1956</u>		REGISTRAR'S SIGNATURE <u>Charles H. Ship</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>Edward Taulson</u>		ADDRESS <u>359 Wash Blvd</u>	



THE UNIVERSITY OF CHICAGO

BUREAU V. S.

MAY 17 1956

RECEIVED

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

## 4724 CERTIFICATE OF DEATH

04718

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Woodlawn Hgts</u>		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Woodlawn Hgts</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>108 Archwood Ave</u>				STREET ADDRESS (If rural give location) <u>108 Archwood Ave.</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last) <u>MABEL L (DENNIS) SCHEMM</u>				<b>4. DATE OF DEATH</b> (Month) (Day) (Year) <u>MAY 8 19 56</u>			
<b>5. SEX</b> <u>Female</u>	<b>6. COLOR OR RACE</b> <u>White</u>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b> <u>Widowed</u>	<b>8. DATE OF BIRTH</b> <u>March 15, 1878 1888</u>		<b>9. AGE last birthday</b> <u>68</u> yrs.	<b>IF UNDER 1 YEAR</b> Months Days Hours Min.	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>House wife</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Own home</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Connellville, Pa.</u>		<b>12. CITIZEN OF WHAT COUNTRY?</b> <u>USA</u>	
<b>13. FATHER'S NAME</b> <u>William John Dennis</u>				<b>14. MOTHER'S MAIDEN NAME</b> <u>Alice M. Dwyer</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.) <u>no</u>		<b>16. SOCIAL SECURITY NO.</b> <u>none</u>		<b>17. INFORMANT &amp; ADDRESS</b> <u>Mrs Wilmer M. Shue-Daughter- Poplar Ave. Annapolis, Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
260X IMMEDIATE CAUSE (A) <u>Coronary Thrombosis</u>						INTERVAL BETWEEN ONSET AND DEATH <u>5-hrs</u>	
ANTECEDENT CAUSE(S) DUE TO (B) <u>Essential Hypertension</u>						<u>10-yr.</u>	
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST, DUE TO (C) <u>Diabetes Mellitus</u>						<u>18-yr.</u>	
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>		<b>19b. MAJOR FINDINGS OF OPERATION</b>				<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>	
<b>21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour) (Min.)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Feb 23, 1950</u>, to <u>Oct 20, 1955</u>, that I last saw the deceased alive on <u>Jan 10, 1956</u>, and that death occurred at <u>3P</u> M, from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>C. Patton</u>		<b>DATE SIGNED</b> <u>May 9, 1956</u>		<b>ADDRESS</b> (Street, city, town, state) <u>Heights</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b> <u>Burial</u>		<b>DATE THEREOF</b> <u>5-11-56</u>		<b>NAME OF CEMETERY OR CREMATORY</b> <u>Grace Episcopal Cemetery</u>		<b>LOCATION</b> (City, town, or county) (State) <u>Elkridge, Md.</u>	
<b>24. REC'D BY REGISTRAR</b> <u>5/11/56</u>		<b>REGISTRAR'S SIGNATURE</b> <u>L. J. Dellb...</u>		<b>25. FUNERAL DIRECTOR'S SIGNATURE</b> <u>HOPPING AND KIRKLEY</u>		<b>ADDRESS</b> <u>GLEN BURNIE, MD.</u>	

# CERTIFICATE OF DEATH

STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE

11/11/50

Name of Deceased		Date of Death	
John Doe		11/11/50	
Age		35	
Sex		Male	
Race		White	
Marital Status		Single	
Place of Birth		Baltimore, Md.	
Usual Residence		100 Broadway Ave.	
Cause of Death		Heart Disease	
Occupation		Teacher	
Signature of Physician		[Signature]	
Signature of Registrar		[Signature]	

1950  
Nov 8

BUREAU V. S.

MAY 11 1950

RECEIVED

PHOTOGRAPH

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 4725 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04719

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE _____ b. COUNTY _____			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>P.O. Liversia Park</u>				c. LENGTH OF STAY IN 1b <u>6 weeks</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Donna</u>	
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Box 239m - Jones station</u>				e. STREET ADDRESS _____		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Philippe ELIJAH - SCOTT</u>				4. DATE OF DEATH <u>May 4</u> Month _____ Day _____ Year <u>1956</u>			
5. SEX <u>M.</u>		6. COLOR OR RACE <u>C.</u>		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>3/16/56</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>		10b. KIND OF BUSINESS OR INDUSTRY _____		11. BIRTHPLACE (State or foreign country) <u>Providence Hosp. Baltimore</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Walter E. SOMMERVILLE</u>				14. MOTHER'S MAIDEN NAME <u>Louise Scott</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>		16. SOCIAL SECURITY NO. <u>NO</u>		17. INFORMANT <u>Louise Scott (Mother)</u> Address _____			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute Pulmonary Infection</u> 527.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____ INTERVAL BETWEEN ONSET AND DEATH <u>2 weeks</u>						19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) _____			
20c. TIME OF INJURY Hour _____ a. m. _____ p. m. _____ Month, Day, Year _____ 19 _____		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) _____		20f. (City or town) _____ (County) _____ (State) _____	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Gustave H. Faubert</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>GUSTAVE H. FAUBERT</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>May 7/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Carpenters</u>		22d. LOCATION (City, town, or county) <u>Jones station</u> (State) <u>MD</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. B. Johnson</u> ADDRESS <u>Annapolis</u>				24a. REC'D BY REGISTRAR <u>MAY 10 1956</u>		24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>	

MEDICAL CERTIFICATION

2

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate stating the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

VS. A15ME(S)  
5M 9/55

2039243393

MASSACHUSETTS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL RECORDS  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

RECEIVED  
MAY 10 1952  
BUREAU V. S.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

Item 12, Film 197 5-14-56 et

04720

## 4726 CERTIFICATE OF DEATH

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Md</u> COUNTY		CITY (If outside corporate limits, write RURAL and give nearest town)		CITY (If outside corporate limits, write RURAL and give nearest town)	
CITY OR TOWN <u>MARLEY PARK</u>		LENGTH OF STAY (in this place) <u>7 years</u>		CITY OR TOWN <u>MARLEY PARK - Glen Burnie Pk</u>		CITY OR TOWN <u>MARLEY PARK - Glen Burnie Pk</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>111 Summit Ave</u>				STREET ADDRESS (If rural give location) <u>111 Summit Ave</u>			
<b>3. NAME OF DECEASED</b> (First) (Middle) (Last)				<b>4. DATE OF DEATH</b> (Month) (Day) (Year)			
<u>Annie Josephine Schreiber</u>				<u>5 7 19 56</u>			
<b>5. SEX</b>	<b>6. COLOR OR RACE</b>	<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>	<b>8. DATE OF BIRTH</b>	<b>9. AGE last birthday</b>	<b>IF UNDER 1 YEAR</b>	<b>IF UNDER 24 HRS.</b>	
<u>FEM</u>	<u>WHITE</u>	<u>WIDOWED</u>	<u>MAY-6-1886</u>	<u>70</u> yrs.	Months	Days	Hours
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Housewife</u>				<u>SCOTLAND</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Jos. Tyson</u>				<u>MARGARET DAVIDSON</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)		<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>			
<u>No</u>		<u>None</u>		<u>Mr. Chas. C. Schreiber - 11 Summit Ave</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
<b>443X IMMEDIATE CAUSE (A)</b>						<b>INTERVAL BETWEEN ONSET AND DEATH</b>	
<u>Inanition</u>							
<b>ANTECEDENT CAUSE(S) DUE TO</b>							
<b>DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>						<u>5 years</u>	
<b>STATING UNDERLYING CAUSE LAST.</b>							
<b>(B) DUE TO</b>							
<u>Cerebral Hemorrhage &amp; Stroke</u>							
<b>(C) DUE TO</b>							
<u>Hypertensive C-V. Disease</u>							
<b>11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>		<b>21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)</b>		<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)			
<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)		<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from <u>Jan</u> <u>19 50</u>, to <u>May 4</u>, <u>19 56</u>, that I last saw the deceased alive on <u>May 4</u>, <u>19 56</u>, and that death occurred at <u>4:15 A.M.</u> from the causes and on the date stated above.</b>							
<b>SIGNATURE</b>				<b>DATE SIGNED</b>			
<u>C. McDonald MD</u>				<u>5-7-56</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>BURIAL</u>				<u>MAY 8 1956</u>			
<b>DATE THEREOF</b>				<b>REGISTRAR'S SIGNATURE</b>			
<u>5-10-1956</u>				<u>L. J. DeAlly</u>			
<b>NAME OF CEMETERY OR CREMATORY</b>				<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>			
<u>Cedar Hill Cem</u>				<u>Thomas J. Kenny</u>			
<b>LOCATION (City, town, or county)</b>				<b>ADDRESS</b>			
<u>Ritchie Bkly.</u>				<u>Hollins</u>			

# 1786 CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, MD.

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. DATE OF DEATH

9. PLACE OF DEATH

10. SIGNATURE OF PHYSICIAN

11. SIGNATURE OF REGISTRAR

12. SIGNATURE OF WITNESSES

13. SIGNATURE OF DECEASED

14. SIGNATURE OF NEXT OF KIN

15. SIGNATURE OF BURIAL

16. SIGNATURE OF INTERMENT

17. SIGNATURE OF CREMATION

18. SIGNATURE OF OTHER

19. SIGNATURE OF OTHER

20. SIGNATURE OF OTHER

21. SIGNATURE OF OTHER

22. SIGNATURE OF OTHER

23. SIGNATURE OF OTHER

24. SIGNATURE OF OTHER

25. SIGNATURE OF OTHER

26. SIGNATURE OF OTHER

27. SIGNATURE OF OTHER

28. SIGNATURE OF OTHER

29. SIGNATURE OF OTHER

30. SIGNATURE OF OTHER

31. SIGNATURE OF OTHER

32. SIGNATURE OF OTHER

33. SIGNATURE OF OTHER

34. SIGNATURE OF OTHER

35. SIGNATURE OF OTHER

36. SIGNATURE OF OTHER

37. SIGNATURE OF OTHER

38. SIGNATURE OF OTHER

39. SIGNATURE OF OTHER

40. SIGNATURE OF OTHER

41. SIGNATURE OF OTHER

42. SIGNATURE OF OTHER

43. SIGNATURE OF OTHER

BUREAU V. 5

MAY 9 1956

RECEIVED

RECEIVED

**INSTRUCTIONS**

**1**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04721

# CERTIFICATE OF DEATH

Reg. Dist. No. 27

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>Anne Arundel</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) TOWN <u>Fort Mead</u>		LENGTH OF STAY (In this place) <u>2-9-A</u>		CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <u>Gambrells</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U.S. Gov't Hospital</u>				STREET ADDRESS (If rural give location) <u>California Ave.</u>			
<b>3. NAME OF DECEASED</b>				<b>4. DATE OF DEATH</b>			
(First) <u>Michael</u> (Middle) <u>A</u> (Last) <u>Shai</u>				(Month) <u>May</u> (Day) <u>29</u> (Year) <u>1956</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Married</u>	8. DATE OF BIRTH <u>Sept. 27, 1904</u>	9. AGE last birthday <u>51</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>		IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>operator</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Post Engineers Service</u>		11. BIRTHPLACE (State or foreign country) <u>New York</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A</u>
13. FATHER'S NAME <u>Frank Shai</u>				14. MOTHER'S MAIDEN NAME <u>Rose Hadwig</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>216-09-2791</u>		17. INFORMANT & ADDRESS <u>Mrs. Mary Shai Gambrells Md.</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>						<b>18. MEDICAL CERTIFICATION</b>	
4201 IMMEDIATE CAUSE (A) <u>Coronary Occlusion</u>						INTERVAL BETWEEN ONSET AND DEATH <u>2 days</u>	
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> P. <input type="checkbox"/>		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from <u>Oct</u>, 19<u>46</u>, to <u>May 29</u>, 19<u>56</u>, that I last saw the deceased alive on <u>May 29</u>, 19<u>56</u>, and that death occurred at <u>7:50 P.M.</u> from the causes and on the date stated above.</b>							
SIGNATURE <u>Edward G. Bennett</u>				ADDRESS (Street, city, town, state) <u>Gambrells Md</u>		DATE SIGNED <u>5-29-56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u>		DATE THEREOF <u>June 1, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>our lady of the field</u>		LOCATION (City, town, or county) (State) <u>Mt. Vernon, Md</u>	
24. REC'D BY REGISTRAR <u>6/6/56</u>		REGISTRAR'S SIGNATURE <u>St. Wm. Ayler</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>St. Wm. Ayler</u>		ADDRESS <u>Glen Burnie, Md</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

NOTED

1. PLACE OF BIRTH

DATE

TIME

DECEASED

DECEASED

ATTEST: I, CLERK OF THE HEALTH DEPARTMENT, DO HEREBY CERTIFY THAT THE FOREGOING IS A TRUE AND CORRECT COPY OF THE ORIGINAL AS FILED IN MY OFFICE.

NOTIFICATION

BUREAU V. S.

JUN 6 1956

RECEIVED

*Handwritten signature*

1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within **24 hours** after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within **72 hours** after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04722

## 4728 CERTIFICATE OF DEATH

Reg. Dist. No. *24*

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <i>Anne Arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL or and give nearest town) <i>Severn</i>		LENGTH OF STAY (in this place) <i>3 Weeks</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Severn</i>		TOWN <i>Severn</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural give location) <i>1</i>			
<b>3. NAME OF DECEASED</b> (Type or Print) <i>Corry T. Slater</i>				<b>4. DATE OF DEATH</b> (Month) <i>May</i> (Day) <i>7</i> (Year) <i>1956</i>			
5. SEX <i>Male</i>	6. COLOR OR RACE <i>White</i>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <i>Widowed</i>	8. DATE OF BIRTH <i>Aug. 3, 1879</i>	9. AGE last birthday <i>76</i> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Electrician (ret.)</i>			10b. KIND OF BUSINESS OR INDUSTRY <i>W.B. &amp; A.P.R.</i>	11. BIRTHPLACE (State or foreign country) <i>Savage, Md.</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>John T. Slater</i>				14. MOTHER'S MAIDEN NAME <i>Hattie Wheeler</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <i>No</i>		16. SOCIAL SECURITY NO. <i>Unknown</i>		17. INFORMANT & ADDRESS <i>Mrs. John Munteen - Severn, Md.</i>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
022X IMMEDIATE CAUSE (A) <i>ABDOMINAL-ANEURYSM</i>				INTERVAL BETWEEN ONSET AND DEATH <i>1 year</i>			
ANTECEDENT CAUSE(S) DUE TO (B) _____							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) _____							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, or INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. _____		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> <i>12-7</i> <b>19</b> <b>to</b> <i>12-7</i> <b>19</b> <b>that I last saw the deceased alive on</b> <i>12-7</i> <b>19</b> <b>and that death occurred at</b> <i>12-7</i> <b>M.</b> <b>from the causes and on the date stated above.</b> <b>SIGNATURE</b> <i>Eustace H. McEachern</i> <b>M.D.</b> <i>Glen Burnie Md</i> <b>DATE SIGNED</b> <i>5/8/56</i> <b>ADDRESS</b> (Street, city, town, state)							
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <i>Burial</i>		DATE THEREOF <i>May 9/56</i>		NAME OF CEMETERY OR CREMATORY <i>Epiphany Ceme</i>		LOCATION (City, town, or county) (State) <i>Odonton Md.</i>	
24. REC'D BY REGISTRAR <i>MAY 10 1956</i>		REGISTRAR'S SIGNATURE <i>L. J. DeAlles</i>		25. FUNERAL DIRECTOR'S SIGNATURE <i>P. S. Slight</i>		ADDRESS <i>Glen Burnie, Md.</i>	



# STATE OF MARYLAND DEPARTMENT OF HEALTH - BALTIMORE 18 CERTIFICATE OF DEATH

Form 10-1-55

1. Name of deceased (Print or write full name)

2. Sex

3. Age

4. Date of birth

5. Place of birth

6. Race

7. Occupation

8. Cause of death

9. Date of death

10. Place of death

11. Signature of physician

12. Signature of registrar

13. Signature of informant

14. Signature of witness

15. Signature of funeral director

16. Signature of undertaker

17. Signature of cemetery

18. Signature of burial place

19. Signature of interment

20. Signature of record

21. Signature of file

22. Signature of index

23. Signature of distribution

24. Signature of return

25. Signature of certificate

26. Signature of death

27. Signature of burial

28. Signature of interment

29. Signature of record

30. Signature of file

31. Signature of index

32. Signature of distribution

33. Signature of return

34. Signature of certificate

35. Signature of death

36. Signature of burial

37. Signature of interment

38. Signature of record

39. Signature of file

40. Signature of index

41. Signature of distribution

42. Signature of return

43. Signature of certificate

44. Signature of death

45. Signature of burial

46. Signature of interment

47. Signature of record

48. Signature of file

49. Signature of index

50. Signature of distribution

51. Signature of return

52. Signature of certificate

53. Signature of death

54. Signature of burial

55. Signature of interment

56. Signature of record

57. Signature of file

58. Signature of index

59. Signature of distribution

60. Signature of return

61. Signature of certificate

62. Signature of death

63. Signature of burial

64. Signature of interment

65. Signature of record

66. Signature of file

67. Signature of index

68. Signature of distribution

69. Signature of return

70. Signature of certificate

BUREAU V. 3

MAY 10 1956

RECEIVED

RECEIVED

## 4729 CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Maryland</u>		COUNTY <u>---</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Fort George G. Meade, Md.</u>		LENGTH OF STAY (in this place) <u>3 Years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>3401.4</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>2803 Windsor Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>JENNIFER</u> (Middle) <u>YUKIE</u> (Last) <u>SMALLWOOD</u>				(Month) <u>May</u> (Day) <u>27</u> (Year) <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>Single</u>		8. DATE OF BIRTH <u>26 May 1956</u>	
9. AGE last birthday <u>0</u> yrs.		IF UNDER 1 YEAR		IF UNDER 24 HRS.			
		Months <u>0</u> Days <u>11</u>		Hours <u>11</u> Min. <u>56</u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>None</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>None</u>		11. BIRTHPLACE (State or foreign country) <u>Maryland</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA A</u>							
13. FATHER'S NAME <u>William Henry Smallwood</u>				14. MOTHER'S MAIDEN NAME <u>Aiko Nomoto Aiko Nomoto</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>				16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT & ADDRESS <u>Father, 2803 Windsor Ave, Baltimore, Maryland</u>	
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				18. MEDICAL CERTIFICATION			
7625 IMMEDIATE CAUSE (A) <u>PREMAUTORITY</u> Prematurity				INTERVAL BETWEEN ONSET AND DEATH			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour) M. <input type="checkbox"/> at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21a. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/>		21i. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>26 May</u> , 19 <u>56</u> , to <u>27 May</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>27 May</u> , 19 <u>56</u> , and that death occurred at <u>6:43 AM</u> from the causes and on the date stated above.							
SIGNATURE <u>THOMAS A. COOK, JR. MD.</u>				ADDRESS (Street, city, town, state) <u>U. S. Army Hospital, Ft. G.G. Meade, Md.</u>			
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Removal</u>		DATE THEREOF <u>29 May 56</u>		NAME OF CEMETERY OR CREMATORY <u>Removed to Medical Lab.</u>		LOCATION (City, town, or county) (State) <u>Anne Arundel County Fort G.G. Meade, Md.</u>	
24. REC'D BY REGISTRAR <u>W.L. Saylor, 1st Lt, MSC</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>None</u>		ADDRESS			
DATE <u>27 May 56</u>							

**INSTRUCTIONS**

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS AISC 1-55 10M

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4730 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04724

Reg. Dist. No. 26

<b>1. PLACE OF DEATH</b> a. COUNTY <u>Anne Arundel</u> <span style="float: right;">MARYLAND</span>				<b>2. USUAL RESIDENCE</b> (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> <span style="float: right;">b. COUNTY <u>Anne Arundel</u></span>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Drury</u>				c. LENGTH OF STAY IN 1b <u>Drury</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)				d. STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or print) <u>ARTHUR</u> <span style="float: right;">Unidentified No. 1 <u>SMITH</u></span>				<b>4. DATE OF DEATH</b> Month <u>May</u> Day <u>7</u> Year <u>19 56</u>			
<b>5. SEX</b> <u>M</u>		<b>6. COLOR OR RACE</b> <u>Colored</u>		<b>7. MARRIED</b> <input type="checkbox"/> <b>NEVER MARRIED</b> <input type="checkbox"/> <b>WIDOWED</b> <input checked="" type="checkbox"/> <b>DIVORCED</b> <input type="checkbox"/>		<b>8. DATE OF BIRTH</b> <u>OCT 1 1878</u>	
<b>9. AGE</b> (In years last birthday) <u>77</u> yrs.		<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired) <u>Farmer</u>		<b>10b. KIND OF BUSINESS OR INDUSTRY</b> <u>Tobacco</u>		<b>11. BIRTHPLACE</b> (State or foreign country) <u>Bristol</u>	
<b>12. CITIZEN OF WHAT COUNTRY?</b>				<b>13. FATHER'S NAME</b> <u>William Owens</u>			
<b>14. MOTHER'S MAIDEN NAME</b> <u>Emily Abrams</u>				<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unknown) <u>No</u>			
<b>16. SOCIAL SECURITY NO.</b>				<b>17. INFORMANT</b> <u>Eugene Smith, Lethbridge Md.</u>			
<b>18. CAUSE OF DEATH</b> [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div style="width: 40%;"> <b>PART I. DEATH WAS CAUSED BY:</b>  <b>IMMEDIATE CAUSE (a)</b>  <u>Extensive arteriosclerotic cardiovascular disease</u>            DUE TO            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.  <b>(b)</b>  <u>History of head injury</u>  <b>DUE TO</b>  <b>(c)</b> </div> <div style="width: 55%;"> <b>INTERVAL BETWEEN ONSET AND DEATH</b> </div> </div>							
<b>PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)</b>							
<b>20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.</b> <input type="checkbox"/>				<b>20b. DESCRIBE HOW INJURY OCCURRED.</b> (Enter nature of injury in Part I or Part II of item 18.) <u>Supposedly beaten over the head</u>			
<b>20c. TIME OF INJURY</b> Month, Day, Year Hour a. m. p. m. <u>19</u>		<b>20d. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		<b>20e. PLACE OF INJURY</b> (Home, farm, factory, street, office bldg., etc.) <u>Home</u>		<b>20f. (City or town)</b> <u>Drury</u>	
<b>(County)</b> <u>Anne Arundel</u>		<b>(State)</b> <u>Md.</u>					
<b>21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/>, Inspection <input type="checkbox"/>, Inquiry <input type="checkbox"/>, and find that death resulted from:</b> Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
<b>ACTUAL SIGNATURE</b> <u>William V. Lovitt, Jr.</u>				<b>DATE SIGNED</b> <u>5/11/56</u>			
<b>EXAMINER'S NAME (Type)</b> <u>William V. Lovitt, Jr., M.D.</u>				<b>CHIEF MEDICAL EXAMINER</b> <input type="checkbox"/> <b>ASSISTANT MEDICAL EXAMINER</b> <input checked="" type="checkbox"/> <b>DEPUTY MEDICAL EXAMINER</b> <input type="checkbox"/>			
<b>22a. BURIAL, CREMATION, REMOVAL (Specify)</b> <u>Burial</u>		<b>22b. DATE THEREOF</b> <u>May 12 1956</u>		<b>22c. NAME OF CEMETERY OR CREMATORY</b> <u>MOSES</u>		<b>22d. LOCATION (City, town, or county)</b> <u>Drury Md.</u>	
<b>23. FUNERAL DIRECTOR'S SIGNATURE</b> <u>Bernard Hardisty</u>				<b>ADDRESS</b> <u>Salisbury Md.</u>			
<b>24a. REC'D BY REGISTRAR</b> <u>DATE 5/14/1956</u>				<b>24b. REGISTRAR'S SIGNATURE</b> <u>Geo B. Dent</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is anticipated, please execute the certificate, signing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PA3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MASSACHUSETTS DEPARTMENT OF HEALTH-BALTIMORE 18  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

BUREAU V. S.

MAY 15 1956

RECEIVED



## CERTIFICATE OF DEATH

04725

Reg. Dist. No.

4731

1. PLACE OF DEATH a. COUNTY <b>Anne Arundel</b> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <b>Maryland</b> b. COUNTY <b>Baltimore City</b>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <b>Crownsville</b>		c. LENGTH OF STAY IN 1b <b>19 days</b>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <b>Crownsville State Hospital</b>		d. STREET ADDRESS <b>Homeless</b>	
3. NAME OF DECEASED (Type or print) First <b>Janie</b> Middle <b>Smith</b> Last <b>Smith</b>		4. DATE OF DEATH Month <b>5</b> Day <b>1</b> Year <b>19 56</b>	
5. SEX <b>Female</b>	6. COLOR OR RACE <b>Negro</b>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <b>Not given</b>
9. AGE (In years last birthday) <b>66 1/2</b> yrs.		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <b>Unknown</b>		10b. KIND OF BUSINESS OR INDUSTRY <b>Unknown</b>	
11. BIRTHPLACE (State or foreign country) <b>Maryland</b>		12. CITIZEN OF WHAT COUNTRY? <b>U. S.</b>	
13. FATHER'S NAME <b>Unknown</b>		14. MOTHER'S MAIDEN NAME <b>Unknown</b>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <b>No</b> (If yes, give war or dates of service) <b>No</b>		16. SOCIAL SECURITY NO. <b>- -</b>	
17. INFORMANT <b>Hospital Records</b>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Degeneration</b> <b>422.2</b> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____			INTERVAL BETWEEN ONSET AND DEATH
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. f. 19 p. m.	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <b>4/12</b> , 19 <b>56</b> , to <b>5/1</b> , 19 <b>56</b> , that I last saw the deceased alive on <b>4/30</b> , 19 <b>56</b> , and that death occurred at <b>4:45 a.m.</b> from the causes and on the date stated above.			
ACTUAL SIGNATURE <b>Ludwig Benedict</b> M.D.		ADDRESS (Street, city or town, state) <b>Crownsville, Md.</b> DATE SIGNED <b>5/1/56</b>	
PHYSICIAN'S NAME (Type) <b>Ludwig Benedict, M. D.</b>			
22a. BURIAL, CREMATION, or other disposal (Specify)	22b. DATE THEREOF <b>5-3-56</b>	22c. NAME OF CEMETERY OR CREMATORY <b>Univ. of Maryland</b>	22d. LOCATION (City, town, or county) (State) <b>Baltimore, Md</b>
23. FUNERAL DIRECTOR'S SIGNATURE <b>William Reese, II - Annapolis, Md</b>		24a. REC'D BY REGISTRAR <b>5/4/56</b>	24b. REGISTRAR'S SIGNATURE <b>L. W. Jones</b>

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



1

INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 14 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

## MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

4732

## CERTIFICATE OF DEATH

04726

Reg. Dist. No. 24

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>MARYLAND</u>		STATE <u>Same</u>		COUNTY <u>Same</u>	
CITY (If outside corporate limits, write RURAL OR end give nearest town) <u>Glen Burnie</u>		LENGTH OF STAY (in this place) <u>5 years</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Vlll Avenue N.W.</u>				STREET ADDRESS (If rural give location) <u>Same</u>			
<b>3. NAME OF DECEASED</b> (Type or Print)				<b>4. DATE OF DEATH</b>			
(First) <u>Thomas William</u> (Middle) <u>Smith</u> (Last)				(Month) <u>May</u> (Day) <u>27th.</u> (Year) <u>56</u>			
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Divorced</u>	8. DATE OF BIRTH <u>2/19/02</u>	9. AGE last birthday <u>54</u> yrs.	IF UNDER 1 YEAR Months	IF UNDER 24 HRS. Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Shop Foreman at Wilson Lumbar Co.</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Seaton, England, Europe.</u>		11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>William Smith</u>				14. MOTHER'S MAIDEN NAME <u>Ann Bragg</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u>		16. SOCIAL SECURITY NO. <u>215 -01-5200</u>		17. INFORMANT & ADDRESS <u>Mrs. Ann Smith, (Mother)</u>			
<b>I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>				<b>18. MEDICAL CERTIFICATION</b>			
148x IMMEDIATE CAUSE (A) <u>Carcinoma of throat and surrounding tissues.</u>				INTERVAL BETWEEN ONSET AND DEATH <u>Over 8 months</u>			
ANTECEDENT CAUSE(S) DUE TO							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE							
STATING UNDERLYING CAUSE LAST. DUE TO							
(C)							
<b>II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION		20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, of INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town) (County) (State)			
21d. TIME OF INJURY (Month) (Day) (Year) (Hour)		21e. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> M. at work <input type="checkbox"/> at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
<b>22. I hereby certify that I attended the deceased from</b> ....., 19....., to....., 19....., that I last saw the deceased alive on....., 19....., and that death occurred at <u>10:35 P.M.</u> from the causes and on the date stated above.							
SIGNATURE <u>Guadalupe H. Parber MD.</u>				M.D. <u>Glen Burnie, Md.</u>		DATE SIGNED <u>5/29/56</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>May 31, 1956 Burial</u>		DATE THEREOF <u>May 31, 1956</u>		NAME OF CEMETERY OR CREMATORY <u>Landon Park</u>		LOCATION (City, town, or county) (State) <u>Baltimore, Md.</u>	
24. REC'D BY REGISTRAR <u>June 6, 1956</u>		REGISTRAR'S SIGNATURE <u>L. J. De Alba</u>		25. FUNERAL DIRECTOR'S SIGNATURE <u>R. L. Singletary</u>		ADDRESS <u>Glen Burnie, Md.</u>	

# CERTIFICATE OF DEATH

REG. NO. 11

ALL INFORMATION HEREON IS TO BE KEPT SECRET

DATE OF DEATH

1900

AGE

SEX

PLACE OF BIRTH

TIME OF DEATH

CAUSE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

DATE OF DEATH

PLACE OF DEATH

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BUREAU V. 2

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JUN 7 1900

Items 13, 14 Film G197 5-24-56 et

4733

## CERTIFICATE OF DEATH

Reg. Dist. No. 23

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Anne Arundel</u>	MARYLAND	STATE <u>Maryland</u>	COUNTY <u>Balts. City</u>
CITY (If outside corporate limits, write RURAL OR and give nearest town) <u>St. Bernie</u>	LENGTH OF STAY (in this place) <u>8 days</u>	CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore City</u>	<u>3401-4</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Plaza Manor Nursing Home Rt 2, Box 376-A</u>		STREET ADDRESS (If rural give location) <u>139 West Hamburg St</u>	
3. NAME OF DECEASED: (First) (Middle) (Last)		4. DATE OF DEATH: (Month) (Day) (Year)	
<u>WALTER B. SPRIGGS</u>		<u>May 17 1956</u>	
5. SEX: <u>Male</u>	6. COLOR OR RACE: <u>Colored</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>July 1900</u>
9. AGE last birthday <u>55</u> yrs.		10. MONTHS <u>17</u> DAYS <u>19</u> HRS. <u>56</u>	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <u>Funeral Director</u>		10b. KIND OF BUSINESS OR INDUSTRY: <u>Undertaker</u>	
11. BIRTHPLACE (State or foreign country): <u>Maryland</u>		12. CITIZEN OF WHAT COUNTRY? <u>Yes - U.S.A.</u>	
13. FATHER'S NAME: <u>Jesse Spriggs</u>		14. MOTHER'S MAIDEN NAME: <u>Mary (maiden name unknown) Spriggs</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.: <u>none</u>	
17. INFORMANT & ADDRESS:			

18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			Interval Between Onset And Death
Immediate cause (a) <u>Cardio-vascular-renal disease</u>			
Antecedent causes (s) (b) <u>Asthma</u>			
(c) <u>none</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION: <u>none</u>			
19b. MAJOR FINDINGS OF OPERATION: <u>none</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>none</u>	PLACE (Home, farm, factory, street, office bldg., etc.) <u>none</u>	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>none</u>	INJURY OCCURRED While at Work <input type="checkbox"/> Not While at Work <input type="checkbox"/>	HOW DID INJURY OCCUR? <u>none</u>	
22. I hereby certify that I attended the deceased from <u>May 17, 1956</u> , to <u>May 17, 1956</u> , that I last saw the deceased alive on <u>May 17, 1956</u> , and that death occurred at <u>8:30 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE (Degree or title) <u>H.F. Manuzak M.D.</u>		ADDRESS <u>901 Edgerly Rd, Glen Burnie, Md.</u>	
DATE SIGNED <u>17 May 1956</u>			
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	DATE THEREOF <u>5-21-56</u>	NAME OF CEMETERY OR CREMATORY <u>MT. Auburn Cem.</u>	LOCATION (City, town, or county) (State) <u>Balto. Md.</u>
DATE REC'D BY LOCAL REGISTRAR <u>5-21-56</u>	REGISTRAR'S SIGNATURE <u>Wm. G. Jackson</u>	24. FUNERAL DIRECTOR <u>Wm. G. Jackson</u>	
916 Penna. ADDRESS <u>Wm. G. Jackson Funeral Home</u>			

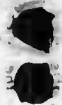
Note: This was a regular patient of Dr. J. Taler of Glen Burnie & I was called by the nursing home to pronounce him dead when Dr. Taler was out of town.

MARGIN RESERVED FOR BINDING

VS. A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





4692

## CERTIFICATE OF DEATH

04728

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>A. H.</i> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind</i> b. COUNTY <i>A. H.</i>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>A. H. Gen Hospital</i>		d. STREET ADDRESS	
3. NAME OF DECEASED (Type or print) <i>Ommer</i> First <i>B</i> Middle <i>Stanford</i> Last		4. DATE OF DEATH <i>May 28</i> 1956 Month <i>May</i> Day <i>28</i> Year <i>1956</i>	
5. SEX <i>Male</i>	6. COLOR OR RACE <i>Caucasian</i>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <i>Jan 26 1884</i> 72 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Cornplanter</i>		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (State or foreign country) <i>Denton Ind</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Andrew J Bailey</i>		14. MOTHER'S MAIDEN NAME <i>Amel Bailey</i>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 17. INFORMANT <i>Mr. Clouse S. Jones</i> Address <i>Denton, Ind</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial Infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Coronary Occlusion</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <i>1 day</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)			19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>
20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from <i>5-19-56</i> , 19____, to <i>5-20-56</i> , 19____, that I last saw the deceased alive on <i>5-19-56</i> , 19____, and that death occurred at _____ M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <i>G.T. Allen</i> M.D.		ADDRESS (Street, city or town, state) DATE SIGNED <i>5-19-56</i>	
PHYSICIAN'S NAME (Type) <i>A.T. ALLEN</i>		<i>62 CHATHAM ST</i>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial May 24/56</i>	22b. DATE THEREOF	22c. NAME OF CEMETERY OR CREMATORY <i>Springvale</i>	22d. LOCATION (City, town, or county) (State) <i>Denton Ind</i>
23. FUNERAL DIRECTOR'S SIGNATURE <i>J.B. Johnson</i> ADDRESS <i>Annapolis</i>		24a. REC'D BY REGISTRAR <i>MAY 28 1956</i> 24b. REGISTRAR'S SIGNATURE <i>M. J. French</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. DATE OF DEATH</p>	
<p>7. CAUSE OF DEATH</p>		<p>8. PLACE OF DEATH</p>	
<p>9. OCCASION OF DEATH</p>		<p>10. SIGNATURE OF DECEASED</p>	
<p>11. SIGNATURE OF WITNESS</p>		<p>12. SIGNATURE OF PHYSICIAN</p>	
<p>13. SIGNATURE OF CLERK</p>		<p>14. SIGNATURE OF REGISTRAR</p>	
<p>15. SIGNATURE OF JUDGE</p>		<p>16. SIGNATURE OF SHERIFF</p>	
<p>17. SIGNATURE OF CORONER</p>		<p>18. SIGNATURE OF JURY</p>	
<p>19. SIGNATURE OF DISTRICT ATTORNEY</p>		<p>20. SIGNATURE OF CLERK OF DISTRICT COURT</p>	
<p>21. SIGNATURE OF CLERK OF DISTRICT COURT</p>		<p>22. SIGNATURE OF CLERK OF DISTRICT COURT</p>	
<p>23. SIGNATURE OF CLERK OF DISTRICT COURT</p>		<p>24. SIGNATURE OF CLERK OF DISTRICT COURT</p>	
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<p>99. SIGNATURE OF CLERK OF DISTRICT COURT</p>		<p>100. SIGNATURE OF CLERK OF DISTRICT COURT</p>	

BUREAU V. S.

MAY 28 1956

RECEIVED

## CERTIFICATE OF DEATH

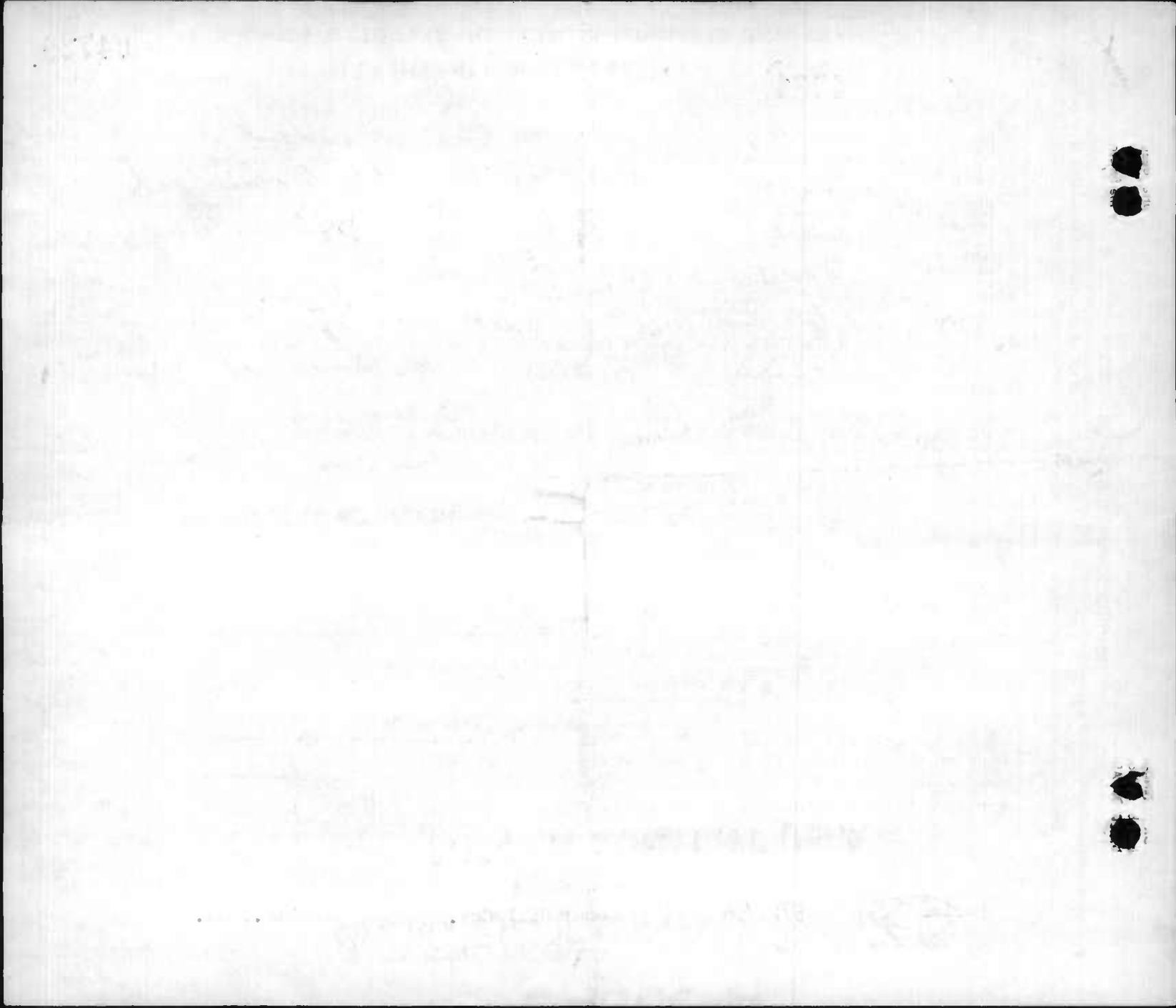
Reg. Dist. No. 21

4734

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <i>anne arundel</i>		MARYLAND		STATE <i>Maryland</i>		COUNTY <i>Anne Arundel</i>	
CITY (If outside corporate limits, write RURAL and give nearest town) <i>Millersville</i>		LENGTH OF STAY (in this place) <i>2 1/2 months</i>		CITY (If outside corporate limits, write RURAL and give nearest town) <i>Glen Burnie, Md.</i>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>Sanna Nursing Home Cecil Rd, Millersville, Md</i>				STREET ADDRESS (If rural give location) <i>Seventh St, Point Pleasant (Glen Burnie P.O.)</i>			
3. NAME OF DECEASED: (First) <i>CHARLES</i> (Middle) <i>HENRY</i> (Last) <i>STRUPP</i>				4. DATE OF DEATH: (Month) <i>May</i> (Day) <i>18</i> (Year) <i>1956</i>			
5. SEX: <i>Male</i>		6. COLOR OR RACE: <i>White</i>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <i>Wid.</i>		8. DATE OF BIRTH: <i>March 29, 1884</i>	
				9. AGE last birthday: <i>72</i> yrs.		10. UNDECEASED 1 YEAR 1P UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired: <i>Cement finisher.</i>		10b. KIND OF BUSINESS OR INDUSTRY: <i>Building</i>		11. BIRTHPLACE (State or foreign country): <i>Baltimore, Md</i>		12. CITIZEN OF WHAT COUNTRY? <i>Yes - U.S.A</i>	
13. FATHER'S NAME: <i>Jacob Strupp (dec.)</i>				14. MOTHER'S MAIDEN NAME: <i>Amelia Rigger (dec.)</i>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS: <i>Mrs Gertrude Helen - Pt. Pleasant, Glen Burnie, Md</i>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						Interval Between Onset And Death	
Immediate cause (a) <i>Cerebral vascular accident</i>						<i>1 day</i>	
Antecedent causes (s) (b) <i>Chronic aortic regurgitation</i>						<i>10 yrs</i>	
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <i>Chronic arteriosclerosis</i>						<i>10 yrs</i>	
11. OTHER SIGNIFICANT CONDITIONS						<i>5 yrs</i>	
Conditions contributing to the death but not related to the disease or condition causing death. <i>Chronic nephritis</i>							
19a. DATE OF OPERATION: <i>none</i>		19b. MAJOR FINDINGS OF OPERATION				20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21. ACCIDENT (Specify) <i>none</i>		PLACE (Home, farm, factory, street, office bldg., etc.)		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <i>May 1955</i> , to <i>18 May 1956</i> , that I last saw the deceased alive on <i>April 17, 1956</i> , and that death occurred at <i>5:30 PM</i> , from the causes and on the date stated above.							
SIGNATURE (Degree or title) <i>H. F. Manuzak M.D.</i>		ADDRESS <i>901 Edgerly Rd, Glen Burnie, Md</i>		DATE SIGNED <i>18 May 1956</i>			
23. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		DATE THEREOF <i>5/21/56</i>		NAME OF CEMETERY OR CREMATORY <i>Cedar Hill Cem.</i>		LOCATION (City, town, or county) (State) <i>Balto., Md.</i>	
DATE RECD BY LOCAL REGISTRAR <i>May 19 1956</i>		REGISTRAR'S SIGNATURE <i>R.W.</i>		24. FUNERAL DIRECTOR <i>Wm. J. Dickner &amp; Sons - Balto.</i>		ADDRESS <i>17 Md.</i>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4693 CERTIFICATE OF DEATH

04730

Reg. Dist. No. 21

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>AA</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOLIS</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>AA GENERAL HOSP</u>		d. STREET ADDRESS <u>WINCHESTER on the SEVERN</u>	
3. NAME OF DECEASED (Type or print) <u>Frederick Leroy Suehs</u>		4. DATE OF DEATH Month <u>5</u> Day <u>12</u> Year <u>1956</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>White</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>4-1-1906</u>
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>DRUG SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>SALESMAN</u>	9. AGE (In years last birthday) <u>50</u> yrs. IF UNDER 1 YEAR: Months <u>5</u> Days <u>12</u> Hours <u>56</u> Min.
11. BIRTHPLACE (State or foreign country) <u>BALTO. MD</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>Frederick Suehs</u>		14. MOTHER'S MAIDEN NAME <u>Augustine Haskett</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>                    </u>	
17. INFORMANT <u>Katherine M. Suehs</u>		Address <u>(2)</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary thrombosis</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Coronary insufficiency</u> DUE TO (c) <u>                    </u>			INTERVAL BETWEEN ONSET AND DEATH <u>1 hr.</u> <u>4 mon.</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>                    </u>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>                    </u>	
20c. TIME OF INJURY Month <u>5</u> Day <u>12</u> Year <u>1956</u> Hour <u>                    </u> a. m. <u>19</u> p. m. <u>                    </u>		20d. INJURY OCCURRED While <input type="checkbox"/> at work Nor while <input type="checkbox"/> at work	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>                    </u>
20f. (City or town) <u>                    </u>		(County) <u>                    </u> (State) <u>                    </u>	
21. I certify that I attended the deceased from <u>5/12/56</u> to <u>5/12/56</u> , that I last saw the deceased alive on <u>5/12/56</u> , 19 <u>56</u> , and that death occurred at <u>11:40</u> M, from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>Frank M. Shipley</u>		ADDRESS (Street, city or town, state) <u>63 College Ave Annapolis</u>	
PHYSICIAN'S NAME (Type) <u>Frank M. Shipley</u>		DATE SIGNED <u>5/12/56</u>	
22a. BURIAL, CREMATION, REINTERMENT <u>                    </u>	22b. DATE THEREOF <u>5-15-56</u>	22c. NAME OF CEMETERY OR CREMATORY <u>HILLCREST MEM.</u>	22d. LOCATION (City, town, or county) (State) <u>ANNAPOLIS MD</u>
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor</u>		ADDRESS <u>63 College Ave Annapolis</u>	
24a. REC'D BY REGISTRAR <u>                    </u>		24b. REGISTRAR'S SIGNATURE <u>                    </u>	
DATE <u>5/15/1956</u>			

# CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH - BOSTON

1956

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>		<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>		<p>7. CAUSE OF DEATH</p>		<p>8. MANNER OF DEATH</p>	
<p>9. DATE OF DEATH</p>		<p>10. TIME OF DEATH</p>		<p>11. PLACE OF DEATH</p>		<p>12. SIGNATURE OF DECEASED</p>	
<p>13. SIGNATURE OF WITNESSES</p>		<p>14. SIGNATURE OF PHYSICIAN</p>		<p>15. SIGNATURE OF CLERK</p>		<p>16. SIGNATURE OF REGISTRAR</p>	
<p>17. SIGNATURE OF DECEASED</p>		<p>18. SIGNATURE OF WITNESSES</p>		<p>19. SIGNATURE OF PHYSICIAN</p>		<p>20. SIGNATURE OF CLERK</p>	
<p>21. SIGNATURE OF REGISTRAR</p>		<p>22. SIGNATURE OF DECEASED</p>		<p>23. SIGNATURE OF WITNESSES</p>		<p>24. SIGNATURE OF PHYSICIAN</p>	
<p>25. SIGNATURE OF CLERK</p>		<p>26. SIGNATURE OF REGISTRAR</p>		<p>27. SIGNATURE OF DECEASED</p>		<p>28. SIGNATURE OF WITNESSES</p>	
<p>29. SIGNATURE OF PHYSICIAN</p>		<p>30. SIGNATURE OF CLERK</p>		<p>31. SIGNATURE OF REGISTRAR</p>		<p>32. SIGNATURE OF DECEASED</p>	
<p>33. SIGNATURE OF WITNESSES</p>		<p>34. SIGNATURE OF PHYSICIAN</p>		<p>35. SIGNATURE OF CLERK</p>		<p>36. SIGNATURE OF REGISTRAR</p>	
<p>37. SIGNATURE OF DECEASED</p>		<p>38. SIGNATURE OF WITNESSES</p>		<p>39. SIGNATURE OF PHYSICIAN</p>		<p>40. SIGNATURE OF CLERK</p>	
<p>41. SIGNATURE OF REGISTRAR</p>		<p>42. SIGNATURE OF DECEASED</p>		<p>43. SIGNATURE OF WITNESSES</p>		<p>44. SIGNATURE OF PHYSICIAN</p>	
<p>45. SIGNATURE OF CLERK</p>		<p>46. SIGNATURE OF REGISTRAR</p>		<p>47. SIGNATURE OF DECEASED</p>		<p>48. SIGNATURE OF WITNESSES</p>	
<p>49. SIGNATURE OF PHYSICIAN</p>		<p>50. SIGNATURE OF CLERK</p>		<p>51. SIGNATURE OF REGISTRAR</p>		<p>52. SIGNATURE OF DECEASED</p>	
<p>53. SIGNATURE OF WITNESSES</p>		<p>54. SIGNATURE OF PHYSICIAN</p>		<p>55. SIGNATURE OF CLERK</p>		<p>56. SIGNATURE OF REGISTRAR</p>	
<p>57. SIGNATURE OF DECEASED</p>		<p>58. SIGNATURE OF WITNESSES</p>		<p>59. SIGNATURE OF PHYSICIAN</p>		<p>60. SIGNATURE OF CLERK</p>	
<p>61. SIGNATURE OF REGISTRAR</p>		<p>62. SIGNATURE OF DECEASED</p>		<p>63. SIGNATURE OF WITNESSES</p>		<p>64. SIGNATURE OF PHYSICIAN</p>	
<p>65. SIGNATURE OF CLERK</p>		<p>66. SIGNATURE OF REGISTRAR</p>		<p>67. SIGNATURE OF DECEASED</p>		<p>68. SIGNATURE OF WITNESSES</p>	
<p>69. SIGNATURE OF PHYSICIAN</p>		<p>70. SIGNATURE OF CLERK</p>		<p>71. SIGNATURE OF REGISTRAR</p>		<p>72. SIGNATURE OF DECEASED</p>	
<p>73. SIGNATURE OF WITNESSES</p>		<p>74. SIGNATURE OF PHYSICIAN</p>		<p>75. SIGNATURE OF CLERK</p>		<p>76. SIGNATURE OF REGISTRAR</p>	
<p>77. SIGNATURE OF DECEASED</p>		<p>78. SIGNATURE OF WITNESSES</p>		<p>79. SIGNATURE OF PHYSICIAN</p>		<p>80. SIGNATURE OF CLERK</p>	
<p>81. SIGNATURE OF REGISTRAR</p>		<p>82. SIGNATURE OF DECEASED</p>		<p>83. SIGNATURE OF WITNESSES</p>		<p>84. SIGNATURE OF PHYSICIAN</p>	
<p>85. SIGNATURE OF CLERK</p>		<p>86. SIGNATURE OF REGISTRAR</p>		<p>87. SIGNATURE OF DECEASED</p>		<p>88. SIGNATURE OF WITNESSES</p>	
<p>89. SIGNATURE OF PHYSICIAN</p>		<p>90. SIGNATURE OF CLERK</p>		<p>91. SIGNATURE OF REGISTRAR</p>		<p>92. SIGNATURE OF DECEASED</p>	
<p>93. SIGNATURE OF WITNESSES</p>		<p>94. SIGNATURE OF PHYSICIAN</p>		<p>95. SIGNATURE OF CLERK</p>		<p>96. SIGNATURE OF REGISTRAR</p>	
<p>97. SIGNATURE OF DECEASED</p>		<p>98. SIGNATURE OF WITNESSES</p>		<p>99. SIGNATURE OF PHYSICIAN</p>		<p>100. SIGNATURE OF CLERK</p>	

RECEIVED  
MAY 16 1956  
BUREAU V. S.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4  
may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director,  
page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with  
the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04731

4735

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH a. COUNTY <u>AA</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Mo.</u> b. COUNTY <u>AA Co.</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>LOTHIAN</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ANNAPOHIS, Mo.</u> 10 d. STREET ADDRESS <u>134 SPAVIEW AVE.</u> e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>GEORGE W. SULLIVAN</u>		4. DATE OF DEATH Month Day Year <u>MAY 18 1956</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>7/29/1900</u> 55 yrs.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>SALESMAN</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>INSURANCE</u>	
11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>GEORGE SULLIVAN</u>		14. MOTHER'S MAIDEN NAME <u>CECELIA F. POPHAM</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>Mrs. MARY SULLIVAN</u> #2		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral thrombosis</u> <u>332X</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Broncho pneumonia</u> DUE TO (c) <u>generalized arteriosclerosis</u>		INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>May 2</u> , 19 <u>56</u> , to <u>May 18</u> , 19 <u>56</u> , that I last saw the deceased alive on <u>May 17</u> , 19 <u>56</u> , and that death occurred at <u>6:30 P.M.</u> , from the causes and on the date stated above. ADDRESS (Street, city or town, state) <u>Lothian, Md.</u> DATE SIGNED <u>5/22/56</u> ACTUAL SIGNATURE <u>Emily H. Wilson</u> M.D. PHYSICIAN'S NAME (Type) <u>Emily H. Wilson</u>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>MAY 21, 56</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>CEDAR BLUFF</u>		22d. LOCATION (City, town, or county) (State) <u>ANNAPOHIS Mo.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John M. Taylor + Sons</u>		24a. REC'D BY REGISTRAR DATE <u>5/22/1956</u>	
ADDRESS <u>Annapolis, Md.</u>		24b. REGISTRAR'S SIGNATURE <u>Emily West Willman</u>	

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE 18

Page One

<p>NAME OF DECEASED <i>George Sullivan</i></p>		<p>DATE OF DEATH <i>May 25 1956</i></p>	
<p>AGE <i>43.11</i></p>		<p>SEX <i>Male</i></p>	
<p>DATE OF BIRTH <i>May 1912</i></p>		<p>PLACE OF BIRTH <i>St. Louis, Mo.</i></p>	
<p>US BIRTH REGISTRATION NO. <i>100-100000</i></p>		<p>DATE OF DEATH <i>May 25 1956</i></p>	
<p>TIME OF DEATH <i>10:00 AM</i></p>		<p>PLACE OF DEATH <i>St. Louis, Mo.</i></p>	
<p>CAUSE OF DEATH <i>Heart Disease</i></p>		<p>IMMEDIATE CAUSE OF DEATH <i>Myocardial Infarction</i></p>	
<p>INTERVIEWED BY <i>Dr. J. H. Smith</i></p>		<p>DATE OF INTERVIEW <i>May 25 1956</i></p>	
<p>SIGNATURE OF PHYSICIAN <i>J. H. Smith</i></p>		<p>DATE OF SIGNATURE <i>May 25 1956</i></p>	
<p>SIGNATURE OF REGISTRAR <i>J. H. Smith</i></p>		<p>DATE OF SIGNATURE <i>May 25 1956</i></p>	

BUREAU V. 8

MAY 25 1956

RECEIVED

4736

## CERTIFICATE OF DEATH

Reg. Dist. No. 20

1. PLACE OF DEATH o. COUNTY <i>A. A.</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>Ind.</i> b. COUNTY <i>A. A.</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Lothian</i>			
c. LENGTH OF STAY IN 1b <i>life</i>				d. STREET ADDRESS			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Henry</i> Middle <i>Thomas</i> Last				4. DATE OF DEATH <i>May 27 1956</i> Month <i>May</i> Day <i>27</i> Year <i>1956</i>			
5. SEX <i>male</i>		6. COLOR OR RACE <i>Colored</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Oct 6 1878</i>	
9. AGE (In years last birthday) <i>77</i> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Teacher</i>		11. BIRTHPLACE (State or foreign country) <i>Lothian</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME <i>Richard Thomas</i>				14. MOTHER'S MARRIED NAME <i>Julia (unmarried)</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)		16. SOCIAL SECURITY NO.		17. INFORMANT <i>Mrs Mary Thomas</i> Address <i>Lothian</i>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Acute Congestive Failure</i> <i>434.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>							
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	
				20f. (City or town) (County) (State)			
21. I certify that I attended the deceased from <i>5-15-56</i> , 19____, to <i>5-25-56</i> , 19____, that I last saw the deceased alive on <i>5-28-56</i> , 19____, and that death occurred at <i>7 1/2</i> M, from the causes and on the date stated above.							
ACTUAL SIGNATURE <i>A. Allen</i> M.D. <i>62</i>				DATE SIGNED <i>62</i>			
PHYSICIAN'S NAME (Type) <i>A T ALLEN</i>				ADDRESS <i>62 CATHEDRAL ST</i>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Buried</i>		22b. DATE THEREOF <i>May 30/56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>Mt Zion</i>		22d. LOCATION (City, town, or county) (State) <i>Lothian Ind</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>Amul A. Johnson</i> ADDRESS <i>Baltimore</i>				24a. REC'D BY REGISTRAR <i>JUN 1 1956</i>		24b. REGISTRAR'S SIGNATURE <i>Clara H. Williams</i>	

MEDICAL CERTIFICATION

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.



CERTIFICATE OF DEATH

BUREAU V. S.

JUN 1 1956

RECEIVED

**MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18**  
**MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

04733

Reg. Dist. No. 1

4694

1. PLACE OF DEATH a. COUNTY <u>ANNE ARUNDEL</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Prince George's</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>10 Annapolis</u>		c. LENGTH OF STAY IN 1b		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Hellside - Maryland 16 X-2 ✓</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>ANNE ARUNDEL GENERAL</u>				d. STREET ADDRESS <u>4506-73rd Ave.</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>William 9 - Vermillion</u>				4. DATE OF DEATH Month <u>5</u> Day <u>8</u> Year <u>1956</u>			
5. SEX <u>M</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>Oct 1, 1906</u>	9. AGE (In years last birthday) <u>49</u> yrs.	IF UNDER 1 YEAR Months <u>  </u> Days <u>  </u>	IF UNDER 24 HRS. Hours <u>  </u> Min. <u>  </u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Crane Operator</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Navy Yard</u>		11. BIRTHPLACE (State or foreign country) <u>Bowie, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>  </u>	
13. FATHER'S NAME <u>Alfred Vermillion</u>				14. MOTHER'S MAIDEN NAME <u>Jennie Trayer</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <u>yes WW II</u>		16. SOCIAL SECURITY NO. <u>  </u>		17. INFORMANT <u>Matthew J. Vermillion</u>		Address <u>4506-73rd Ave. Md.</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] <div style="display: flex; justify-content: space-between;"> <div> <p>PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture Cervical Vertebrae</u>  <u>825X</u>            DUE TO <u>Fracture Skull</u>            Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.            (b) <u>  </u>            DUE TO <u>  </u>            (c) <u>  </u> </p> </div> <div> <p>INTERVAL BETWEEN ONSET AND DEATH <u>  </u></p> </div> </div>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>  </u>							
20a. EXTERNAL CAUSE WAS PRIMARY or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Auto Accident</u>					
20c. TIME OF INJURY Month <u>May</u> Day <u>5</u> Year <u>56</u> Hour <u>  </u> a. m. <u>  </u> p. m. <u>  </u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Highway</u>		20f. (City or town) (County) (State) <u>A.A.C. MD</u>	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> . Accident <input checked="" type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>E. Linhardt</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) <u>E. Linhardt</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>May 18, 1956</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Green Hill</u>		22d. LOCATION (City, town, or county) (State) <u>Smithfield Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>J. Hallinan Sons Co</u>				ADDRESS <u>3004 2nd St. N.E. Wash. D.C.</u>		24a. REC'D BY REGISTRAR <u>5/12/1956</u>	
				24b. REGISTRATION SIGNATURE <u>O. Ornel</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate filing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

NEW YORK STATE DEPARTMENT OF HEALTH - ALBANY 18  
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

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Col. 1.1900 49

George Washington  
 1890-1900  
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 1890-1900  
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BUREAU V. S.

MAY 15 1956

RECEIVED

George Washington  
 1890-1900  
 4502 7324  
 1890-1900  
 4502 7324

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4737 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04734  
73

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <u>Anne-Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>md.</u> b. COUNTY <u>A.A.</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garland Park</u>		c. LENGTH OF STAY IN 1b <u>30 yrs</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Garland Park</u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>400 Broadview Blvd</u>				d. STREET ADDRESS <u>400 Broadview Blvd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First <u>Anne</u> Middle <u>M.</u> Last <u>Wade</u>				4. DATE OF DEATH Month <u>5</u> Day <u>27</u> Year <u>1956</u>			
5. SEX <u>Female</u>	6. COLOR OR RACE <u>white</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>8/16/1888</u>	9. AGE (In years last birthday) <u>67</u> yrs.	IF UNDER 1 YEAR Months Days		IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>House work at home</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>at home</u>		11. BIRTHPLACE (State or foreign country) <u>Ireland</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Patrick Rooney</u>				14. MOTHER'S MAIDEN NAME <u>Anne Whalen</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/>		16. SOCIAL SECURITY NO. <input type="checkbox"/>		17. INFORMANT <u>Mr William P. Lahan</u> Address <u>18 So. Frankforttown Rd.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u> 331X DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Hypertension</u> DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>1/2 hour</u> <u>several years</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>none</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>R. M. McLaughlin</u>				M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>R. M. McLaughlin</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		<u>May 27, 1956</u>	
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/30/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>New Cathedral Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>4300 Old Frederick Rd.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>John J. Cowan</u>				ADDRESS <u>10111 St.</u>		24a. REC'D BY REGISTRAR DATE <u>5/29/56</u>	
				24b. REGISTRAR'S SIGNATURE <u>Dr. Caldwell Woodruff</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MAY 31 1956

RECEIVED



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INSTRUCTIONS

**TO ATTENDING PHYSICIAN OR HOSPITAL:** The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

**TO FUNERAL DIRECTOR:** The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04739

4740

## CERTIFICATE OF DEATH

Reg. Dist. No. ....

<b>1. PLACE OF DEATH</b>				<b>2. USUAL RESIDENCE (HOME) OF DECEASED</b>			
COUNTY <u>Anne Arundel</u>		STATE <u>Maryland</u>		CITY (If outside corporate limits, write RURAL and give nearest town) <u>Baltimore</u>		TOWN <u>Baltimore</u>	
CITY (If outside corporate limits, write RURAL and give nearest town) <u>Wheat Branch</u>		LENGTH OF STAY (in this place)		STREET ADDRESS (If rural give location) <u>1120 Carey St.</u>		ADDRESS	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>Playe Manor Conv. Home</u>				STREET ADDRESS			
<b>3. NAME OF DECEASED</b> (Type or Print)		<b>4. DATE OF DEATH</b>		<b>5. SEX</b>		<b>6. COLOR OR RACE</b>	
<u>Ever</u>		<u>WRIGHT</u>		<u>F</u>		<u>C</u>	
First		Last		Middle		Date	
<u>Ever</u>		<u>WRIGHT</u>		<u>WRIGHT</u>		<u>WRIGHT</u>	
<b>7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)</b>		<b>8. DATE OF BIRTH</b>		<b>9. AGE last birthday</b>		<b>10. IF UNDER 1 YEAR</b>	
<u>Single</u>		<u>March 12, 1886</u>		<u>70</u> yrs.		<u>Months</u> <u>Days</u> <u>Hours</u> <u>Min.</u>	
<b>10a. USUAL OCCUPATION</b> (Give kind of work done during most of working life, even if retired)		<b>10b. KIND OF BUSINESS OR INDUSTRY</b>		<b>11. BIRTHPLACE</b> (State or foreign country)		<b>12. CITIZEN OF WHAT COUNTRY?</b>	
<u>Seamstress</u>		<u>Single</u>		<u>Topeka Kansas</u>		<u>U.S.A.</u>	
<b>13. FATHER'S NAME</b>				<b>14. MOTHER'S MAIDEN NAME</b>			
<u>Welborn Wright</u>				<u>Betty Lee</u>			
<b>15. WAS DECEASED EVER IN U. S. ARMED FORCES?</b> (Yes, no, or unk.)				<b>16. SOCIAL SECURITY NO.</b>		<b>17. INFORMANT &amp; ADDRESS</b>	
<u>(If Yes, give war or dates of service)</u>				<u>1120</u>		<u>Bernard Lee W. Carey</u>	
<b>18. MEDICAL CERTIFICATION</b>							
<b>1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH</b>							
<u>157X IMMEDIATE CAUSE (A) Carcinoma of the</u>							
<u>pancreas</u>							
<b>2. ANTECEDENT CAUSE(S) DUE TO</b>							
<b>3. DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE</b>							
<b>4. STATING UNDERLYING CAUSE LAST.</b>							
<b>11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.</b>							
<b>19a. DATE OF OPERATION</b>				<b>19b. MAJOR FINDINGS OF OPERATION</b>			
<u>157X</u>				<u>157X</u>			
<b>20. AUTOPSY?</b> YES <input type="checkbox"/> NO <input type="checkbox"/>				<b>21. HOW DID INJURY OCCUR?</b>			
<b>21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)</b>				<b>21b. PLACE (Home, farm, lecture, of INJURY street, office bldg., etc.)</b>			
<b>21c. WHERE DID INJURY OCCUR?</b> (City or town) (County) (State)				<b>21d. TIME OF INJURY</b> (Month) (Day) (Year) (Hour)			
<b>21e. INJURY OCCURRED</b> While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>				<b>21f. HOW DID INJURY OCCUR?</b>			
<b>22. I hereby certify that I attended the deceased from May 8, 1956, to May 12, 1956, that I last saw the deceased alive on May 8, 1956, and that death occurred at 6:30 P.M. from the causes and on the date stated above.</b>							
<b>SIGNATURE</b> <u>Joseph Tate</u>				<b>DATE SIGNED</b> <u>5-12-1956</u>			
<b>23. BURIAL, CREMATION, REMOVAL (SPECIFY)</b>				<b>24. REC'D BY REGISTRAR</b>			
<u>Burial</u>				<u>L. J. Sullivan</u>			
<b>25. FUNERAL DIRECTOR'S SIGNATURE</b>				<b>ADDRESS</b>			
<u>Wm. G. Jackson</u>				<u>7. H.</u>			

MAY 17 1956



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04735

4695

## CERTIFICATE OF DEATH

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY <i>aa</i> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <i>md</i> b. COUNTY <i>aa</i>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>10 Annapolis</i>				c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Annapolis</i>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <i>Robert</i> Middle <i>G</i> Last <i>Willis</i>				4. DATE OF DEATH Month <i>5-</i> Day <i>29</i> Year <i>1956</i>			
5. SEX <i>Male</i>		6. COLOR OR RACE <i>White</i>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <i>Sept 5<sup>th</sup> 1898</i>	
9. AGE (In years last birthday) <i>57</i> yrs.		IF UNDER 1 YEAR Months Days Hours Min.		IF UNDER 24 HRS. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>LTJ. Sr. Vet.</i>				10b. KIND OF BUSINESS OR INDUSTRY <i>Navy</i>		11. BIRTHPLACE (State or foreign country) <i>Cowego N. Y.</i>	
12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i>							
13. FATHER'S NAME <i>Manley Willis</i>				14. MOTHER'S MAIDEN NAME <i>Mabel D. Chestnut</i>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>yes</i>		16. SOCIAL SECURITY NO. <i>1921-1935</i>		17. INFORMANT <i>Elise Gladden Willis</i>		Address <i>(2)</i>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Myocardial infarction</i> <i>420.1</i> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Hypertensive arteriosclerotic cardiovascular dis.</i> DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Cirrhosis of liver</i>							INTERVAL BETWEEN ONSET AND DEATH <i>5 minutes</i> <i>2 yrs.</i>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <i>19</i>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <i>December, 1953</i> , to <i>May 29, 1956</i> , that I last saw the deceased alive on <i>May 15, 1956</i> , and that death occurred at <i>7:30</i> P. M., from the causes and on the date stated above. ADDRESS (Street, city or town, state) <i>524/56</i> DATE SIGNED ACTUAL SIGNATURE <i>John L. Hederman</i> M.D. <i>90 Cathedral St. Annapolis, Md.</i> PHYSICIAN'S NAME (Type)							
22a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		22b. DATE THEREOF <i>6-1-56</i>		22c. NAME OF CEMETERY OR CREMATORY <i>National</i>		22d. LOCATION (City, town, or county) (State) <i>Arlington Va</i>	
23. FUNERAL DIRECTOR'S SIGNATURE <i>John M. Taylor Sons</i>				ADDRESS <i>Annapolis Md.</i>		24a. REC'D BY REGISTRAR DATE <i>6/1/56</i>	
				24b. REGISTRAR'S SIGNATURE <i>J. J. O'Connell</i>			

# CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 10

MARYLAND

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

AGE

SEX

RACE

EDUCATION

RELIGION

OCCUPATION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF MARRIAGE

PLACE OF MARRIAGE

DATE OF DEATH

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PLACE OF DEATH

BUREAU K. B.

JUN 4 1956

RECEIVED

MEDICAL CERTIFICATION

VS. A15ME(5)  
5M 9/55



REGELVÄRD

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

04737

4696

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

21

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> <u>MARYLAND</u>				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Pa.</u> b. COUNTY <u></u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Annapolis</u>				c. LENGTH OF STAY IN 1b <u></u>			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Anne Arundel General Hospital</u>				e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>GALDA</u> Middle <u>WISENBAKER</u> Last <u></u>				4. DATE OF DEATH Month <u>May</u> Day <u>22</u> Year <u>1956</u>			
5. SEX <u>Female</u>		6. COLOR OR RACE <u>White</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>Nov. 19, 1907</u>	
9. AGE (In years last birthday) <u>48</u> yrs.		IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		IF UNDER 24 HRS. Months <u></u> Days <u></u> Hours <u></u> Min. <u></u>		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Own Home</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>		12. CITIZEN OF WHAT COUNTRY? <u>U. S. A.</u>	
13. FATHER'S NAME <u>Oakley Williams</u>				14. MOTHER'S MAIDEN NAME <u>Lona Pulliam</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u></u>		16. SOCIAL SECURITY NO. <u></u>		17. INFORMANT <u>McGee Funeral Home Glenville, W. Va.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fracture of 7th cervical vertebra</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u></u> DUE TO (c) <u></u>							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u></u>							
20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>Fell out of moving car</u>					
20c. TIME OF INJURY Hour <u>7</u> P. m. <u>5/22</u> 19 <u>56</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input checked="" type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>street</u>		20f. (City or town) <u>Chesapeake Bay Bridge</u> (County) <u></u> (State) <u>Md.</u>	
21. I certify that I took charge of the remains described above, held an <u>Autopsy</u> <input checked="" type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>William V. Lovitt, Jr.</u>		M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED <u>5/23/56</u>			
EXAMINER'S NAME (Type) <u>William V. Lovitt, Jr., M.D.</u>		ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/26/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Cedarville Cemetery</u>		22d. LOCATION (City, town, or county) (State) <u>Gilmer Co. West Virginia</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>R. Lynn McGee</u>		ADDRESS <u>Glenville, W. Va.</u>		24a. REC'D BY REGISTRAR <u>MAY 28 1956</u>		24b. REGISTRAR'S SIGNATURE <u>Thos. J. Lench</u>	

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

RECEIVED

# MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

## 4739 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

04738

Reg. Dist. No. 24

1. PLACE OF DEATH a. COUNTY <u>Anne Arundel</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Same</u> b. COUNTY			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Glen Burnie</u>			c. LENGTH OF STAY IN 1b <u>4 years</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Same</u>		
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Old Stage Road</u>				d. STREET ADDRESS <u>Same</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) <u>Sophia M. Wolf</u>				4. DATE OF DEATH <u>May 7th.</u> 19 <u>56</u>			
5. SEX <u>F.</u>	6. COLOR OR RACE <u>W</u>	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12/4/87</u>		9. AGE (In years last birthday) <u>68</u> yrs.	IF UNDER 1 YEAR Months Days	IF UNDER 24 HRS. Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housekeeper</u>			10b. KIND OF BUSINESS OR INDUSTRY <u>Unknown</u>		11. BIRTHPLACE (State or foreign country) <u>Cambridge, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>
13. FATHER'S NAME <u>John Collins</u>				14. MOTHER'S MAIDEN NAME <u>Sarah E. Gould</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>None</u>		17. INFORMANT <u>Prudential Ins. Co. Policy.</u>			
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____							INTERVAL BETWEEN ONSET AND DEATH <u>Sudden</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE <u>Eustave H. Faubert</u> M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		DATE SIGNED	
EXAMINER'S NAME (Type) <u>Eustave H. Faubert M.D.</u>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		<u>5/8/56</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		22b. DATE THEREOF <u>5/10/56</u>		22c. NAME OF CEMETERY OR CREMATORY <u>Glen Haven Cemo.</u>		22d. LOCATION (City, town, or county) (State) <u>Glen Burnie, Md.</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>W. Singleton</u>				ADDRESS <u>Glen Burnie, Md.</u>		24a. REC'D BY REGISTRAR DATE <u>May 10-56</u>	
				24b. REGISTRAR'S SIGNATURE <u>L. J. DeAlba</u>			

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay occurs, please execute the certificate within the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

MARYLAND STATE DEPARTMENT OF HEALTH - BALTIMORE 10  
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

NAME OF DECEASED		AGE		SEX		RACE		RELIGION	
DATE OF DEATH		TIME OF DEATH		PLACE OF DEATH		CAUSE OF DEATH		MANNER OF DEATH	
SIGNATURE OF MEDICAL EXAMINER		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CORONER		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF JURY		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF WITNESSES		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF FUNERAL HOME		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF BURIAL PLACE		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF INTERVIEWER		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF INVESTIGATOR		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ASSISTANT		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CLERK		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF RECEPTIONIST		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MAIL ROOM		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF TELEPHONE ROOM		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF RECORDS SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF IDENTIFICATION SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF LABORATORY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF RADIOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PATHOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ANATOMY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF HISTOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CYTOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MICROBIOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF IMMUNOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF EPIDEMIOLOGY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PREVENTIVE MEDICINE SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PUBLIC HEALTH SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF COMMUNITY HEALTH SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF SCHOOL HEALTH SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF OCCUPATIONAL HEALTH SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ENVIRONMENTAL HEALTH SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF FOOD AND DRUG SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF NURSING SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PHYSICIAN SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF DENTIST SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF OPTICIAN SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PODIATRIST SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF VETERINARIAN SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF NUTRITION SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PHYSICAL THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF OCCUPATIONAL THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF RECREATION THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ART THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MUSIC THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF DANCE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF GARDEN THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PET THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF EQUINE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF AERIAL THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF WATER THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CLIMATE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF LIGHT THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF SOUND THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF TOUCH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF TASTE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF SMELL THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PAIN THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF STRESS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ANXIETY THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF DEPRESSION THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF BIPOLAR THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF SCHIZOPHRENIA THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PSYCHOTIC THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MANIC THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF DEMENTIA THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ALZHEIMER THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PARKINSON THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF HUNTINGTON THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF HEMIPARESIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PARAPARESIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF QUADRIPARESIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CEREBRAL PALSY THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MUSCULAR DYSTROPHY THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PHENYLKETONURIA THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF GALACTOSEMIA THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MUCOPOLYSACCHARIDOSIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF GLYCOGEN STORAGE DISEASE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF LYSOSOMAL STORAGE DISEASE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MITOCHONDRIAL DISEASE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PEROXISOMAL DISEASE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF POLYCYSTIC OVARY SYNDROME THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF PCOS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ENDOMETRIOSIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ADENOMYOSIS THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF UTERINE FIBROID THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF OVARIAN CYST THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ECTOPIC PREGNANCY THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF MISCARRIAGE THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF STILLBORN THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF NEONATAL DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF INFANT DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF CHILD DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ADOLESCENT DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF YOUNG ADULT DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ADULT DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF ELDERLY DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF NATURAL CAUSE DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF SUICIDE DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF HOMICIDE DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF UNNATURAL CAUSE DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	
SIGNATURE OF UNKNOWN CAUSE DEATH THERAPY SECTION		DATE		PLACE		TITLE		OFFICE	

BUREAU V. S.

MAY 11 1956

RECEIVED



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INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

04740

4741

## CERTIFICATE OF DEATH

Reg. Dist. No. 27

1. PLACE OF DEATH				2. USUAL RESIDENCE (HOME) OF DECEASED			
COUNTY <u>Anne Arundel</u>		MARYLAND		STATE <u>Ohio</u>		COUNTY <u>Franklin</u>	
CITY (If outside corporate limits, write RURAL and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits, write RURAL and give nearest town)			
TOWN <u>Fort G. G. Meade, Md.</u>		<u>3 Months</u>		TOWN <u>Columbus</u>		<u>72x-3</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>U. S. Army Hospital</u>				STREET ADDRESS (If rural give location) <u>417 Welch Avenue</u>			
3. NAME OF DECEASED (Type or Print)				4. DATE OF DEATH			
(First) <u>SUSAN</u> (Middle) <u>BERNICE</u> (Last) <u>YOUNG</u>				(Month) <u>May</u> (Day) <u>27</u> (Year) <u>19 56</u>			
5. SEX	6. COLOR OR RACE	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify)	8. DATE OF BIRTH	9. AGE last birthday		IF UNDER 24 HRS.	
<u>Female</u>	<u>White</u>	<u>Single</u>	<u>May 27, 1956</u>	yrs. <u>12</u> Months <u>12</u> Days <u>40</u> Hours <u>40</u> Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY		11. BIRTHPLACE (State or foreign country)		12. CITIZEN OF WHAT COUNTRY?	
<u>None</u>		<u>None</u>		<u>Maryland</u>		<u>USA</u>	
13. FATHER'S NAME <u>Charles W. Young</u>				14. MOTHER'S MAIDEN NAME <u>Mie Sakurai</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.)		16. SOCIAL SECURITY NO.		17. INFORMANT & ADDRESS			
<u>No</u>		<u>None</u>		<u>Father, Co C, 1st Bn, 2AC, Fort George G. Meade, Maryland</u>			
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						18. MEDICAL CERTIFICATION	
IMMEDIATE CAUSE (A) <u>Prematurity</u>						INTERVAL BETWEEN ONSET AND DEATH <u>4hrs 40 min</u>	
ANTECEDENT CAUSE(S) DUE TO <u>Premature separation of placenta</u>							
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE DUE TO <u>Premature Separation of placenta</u>							
STATING UNDERLYING CAUSE LAST. (C)							
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION		19b. MAJOR FINDINGS OF OPERATION					
21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)		21c. WHERE DID INJURY OCCUR? (City or town)		(County) (State)	
21d. TIME OF INJURY (Month) (Day) (Year)		21e. INJURY OCCURRED While at work Not while at work		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>27 May 1956</u> , to <u>27 May 1956</u> , that I last saw the deceased alive on <u>27 May 1956</u> , and that death occurred at <u>8:50 PM</u> , from the causes and on the date stated above.							
SIGNATURE <u>KENWYN G. NELSON, CAPT., MC.</u>				ADDRESS (Street, city, town, state) <u>USAH, Ft. G. G. Meade, Md.</u>		DATE SIGNED <u>27 May 1956</u>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Removal</u>		<u>29 May 56</u>		<u>Removed to Medical Lab</u>		<u>Anne Arundel County Ft. G. G. Meade, Md.</u>	
24. REC'D BY REGISTRAR		REGISTRAR'S SIGNATURE		25. FUNERAL DIRECTOR'S SIGNATURE		ADDRESS	
DATE <u>28 May 56</u>		<u>W.L.SAYLOR, 1ST LT, MSC</u>		<u>Nond</u>			

# CERTIFICATE OF DEATH

FILE NO. 370

1. NAME OF DECEASED

2. SEX

3. AGE

4. DATE OF BIRTH

5. PLACE OF BIRTH

6. OCCUPATION

7. CAUSE OF DEATH

8. MANNER OF DEATH

9. TIME OF DEATH

10. PLACE OF DEATH

11. SIGNATURE OF PHYSICIAN

12. SIGNATURE OF REGISTRAR

13. SIGNATURE OF WITNESSES

14. SIGNATURE OF DECEASED

15. SIGNATURE OF NEXT OF KIN

16. SIGNATURE OF BURIAL OFFICIAL

17. SIGNATURE OF CHURCH OFFICIAL

18. SIGNATURE OF FUNERAL HOME

19. SIGNATURE OF CEMETERY

20. SIGNATURE OF INTERVIEWER

21. SIGNATURE OF INTERVIEWER

22. SIGNATURE OF INTERVIEWER

23. SIGNATURE OF INTERVIEWER

24. SIGNATURE OF INTERVIEWER

25. SIGNATURE OF INTERVIEWER

26. SIGNATURE OF INTERVIEWER

27. SIGNATURE OF INTERVIEWER

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31. SIGNATURE OF INTERVIEWER

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33. SIGNATURE OF INTERVIEWER

34. SIGNATURE OF INTERVIEWER

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48. SIGNATURE OF INTERVIEWER

49. SIGNATURE OF INTERVIEWER

50. SIGNATURE OF INTERVIEWER

51. SIGNATURE OF INTERVIEWER

52. SIGNATURE OF INTERVIEWER

53. SIGNATURE OF INTERVIEWER

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55. SIGNATURE OF INTERVIEWER

56. SIGNATURE OF INTERVIEWER

57. SIGNATURE OF INTERVIEWER

58. SIGNATURE OF INTERVIEWER

59. SIGNATURE OF INTERVIEWER

60. SIGNATURE OF INTERVIEWER

BUREAU A. 1

MAY 31 1956

RECEIVED

MASSACHUSETTS